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Appointment Lag Time and Tracking Transition in Young Adults

Sean DeLacey, MD; Naomi Sullivan, MEd, MS, RN, MBA; Laura Levin, DO; Naomi R. Fogel, MD

Ann & Robert H. Lurie Children's Hospital of Chicago
Division of Endocrinology
Center for Quality and Safety
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Disclosures

- I have no relevant financial or non-financial disclosures

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Lurie Children's Hospital Diabetes Program

- Main campus downtown Chicago
  - 8 suburban satellites
- Diverse T1D population
  - ~26% Hispanic, ~56% White/Non-Hispanic, ~8% Black/Non-Hispanic
- ~40-50% Medicaid
- ~1200 T1D patients (~400 with T2D)
- T1D Exchange QI Collaborative since Jan 2021
- Diabetes Team
  - 12 Physicians, 4 Fellows, 1 Nurse Practitioner (hiring 2 additional), 13 RN/CDCES, 3 RD/CDCES, 2 Psychologists, 2 Social Workers

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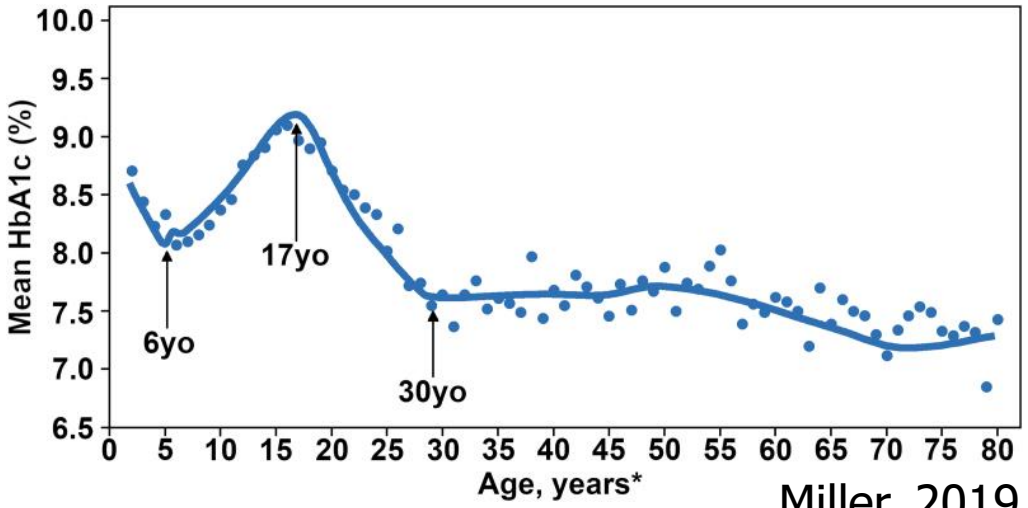
Transition in Type 1 Diabetes

- Transfer from pediatric to adult providers is a sensitive time for Type 1 Diabetes care and is part of a transition process (Miller 2019, Benoit 2020)
- If transition is not appropriately discussed, transfer of care is often frustrating (Varty 2020)
- Delay in transfer can lead to gaps in care and sub-optimal outcomes (Cardario 2009)
- Racial/ethnic disparities exist in outcomes for young adults with Type 1 Diabetes (Agarwal 2020)



Miller, 2019

TRANSITION

~14 years old

Transfer of Care

~23 years old

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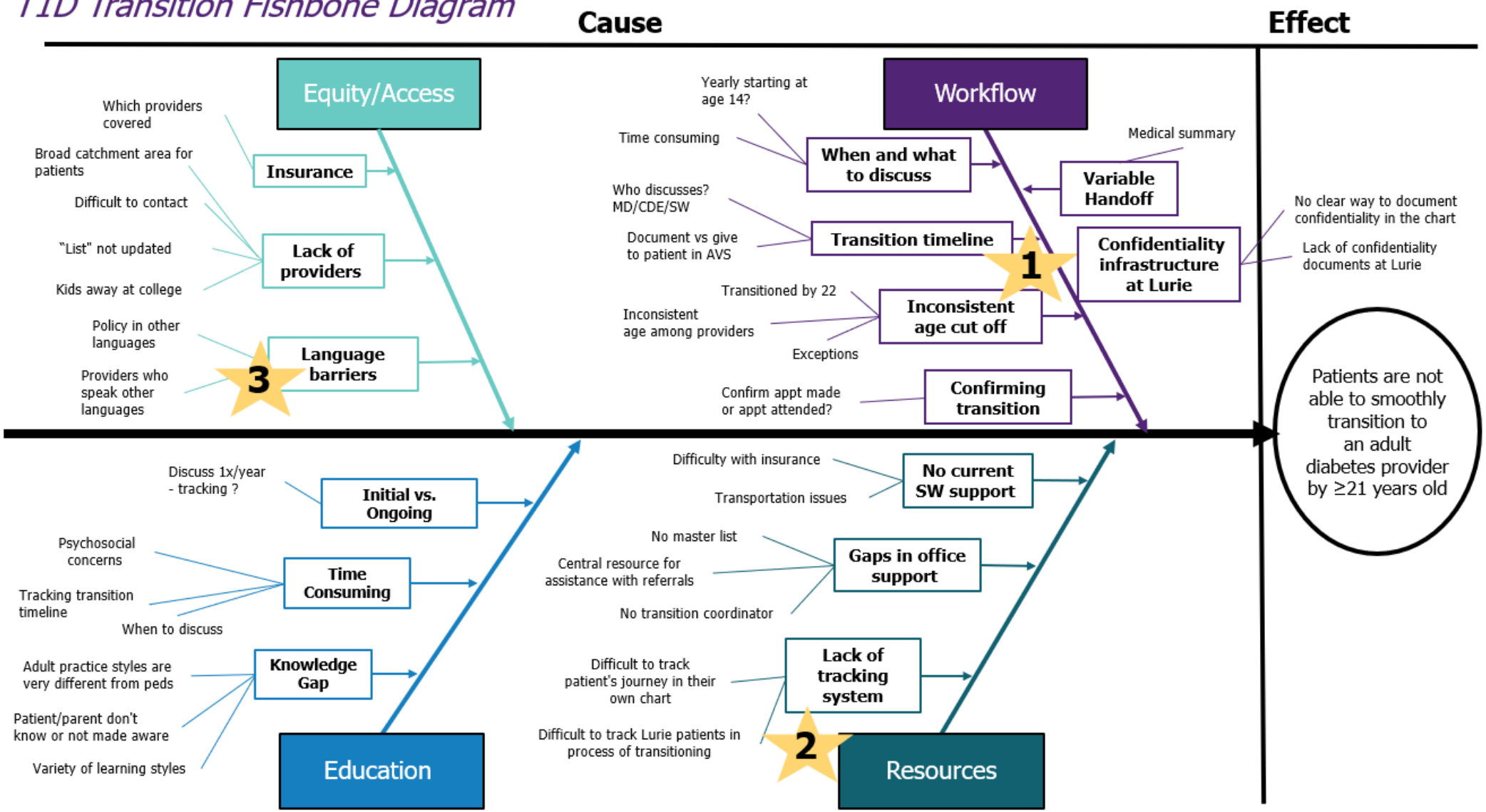
T1D Transition Fishbone Diagram



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T1D Exc

1. Decrease the number of Type diabetes patien 21years old wh are seen each month in pedia endocrinology l 10% by 12/31/
2. Decrease the ti between the la pediatric visit a the first adult v (new interventi no baseline dat and increase th number of pati with a complet adult appointm each month by 10% by 12/31/
3. Increase the discussion of transition durin clinic appointm for patients ≥ 1 years old (new intervention; n baseline data) l 12/31/2023

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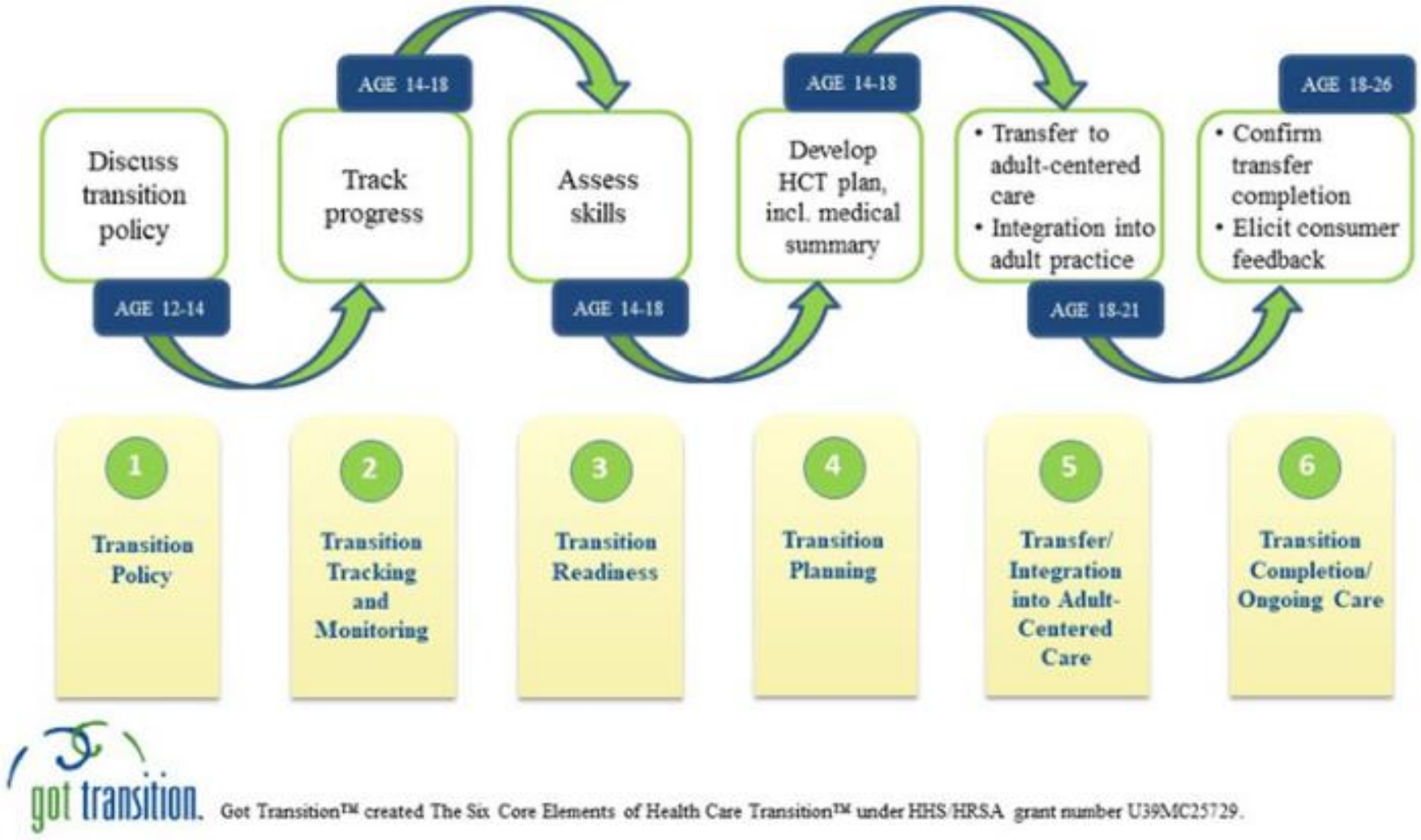

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Development and Implementation: PDSA 1 &2

Endocrinology Medical Transition Policy

Medical transition from adolescence to adulthood is a journey that culminates in the eventual transfer of care to adult physicians. Lurie Children's Division of Pediatric Endocrinology values the importance of preparing youth for a smooth transition to adult health care. This involves a collective effort between you the patient, the medical team, and your family beginning around age 14. **Patients in our practice will transfer their medical care to adult providers sometime between 18 and 20 years of age, but no later than age 21.** We will work with you and your family to develop an individualized plan.

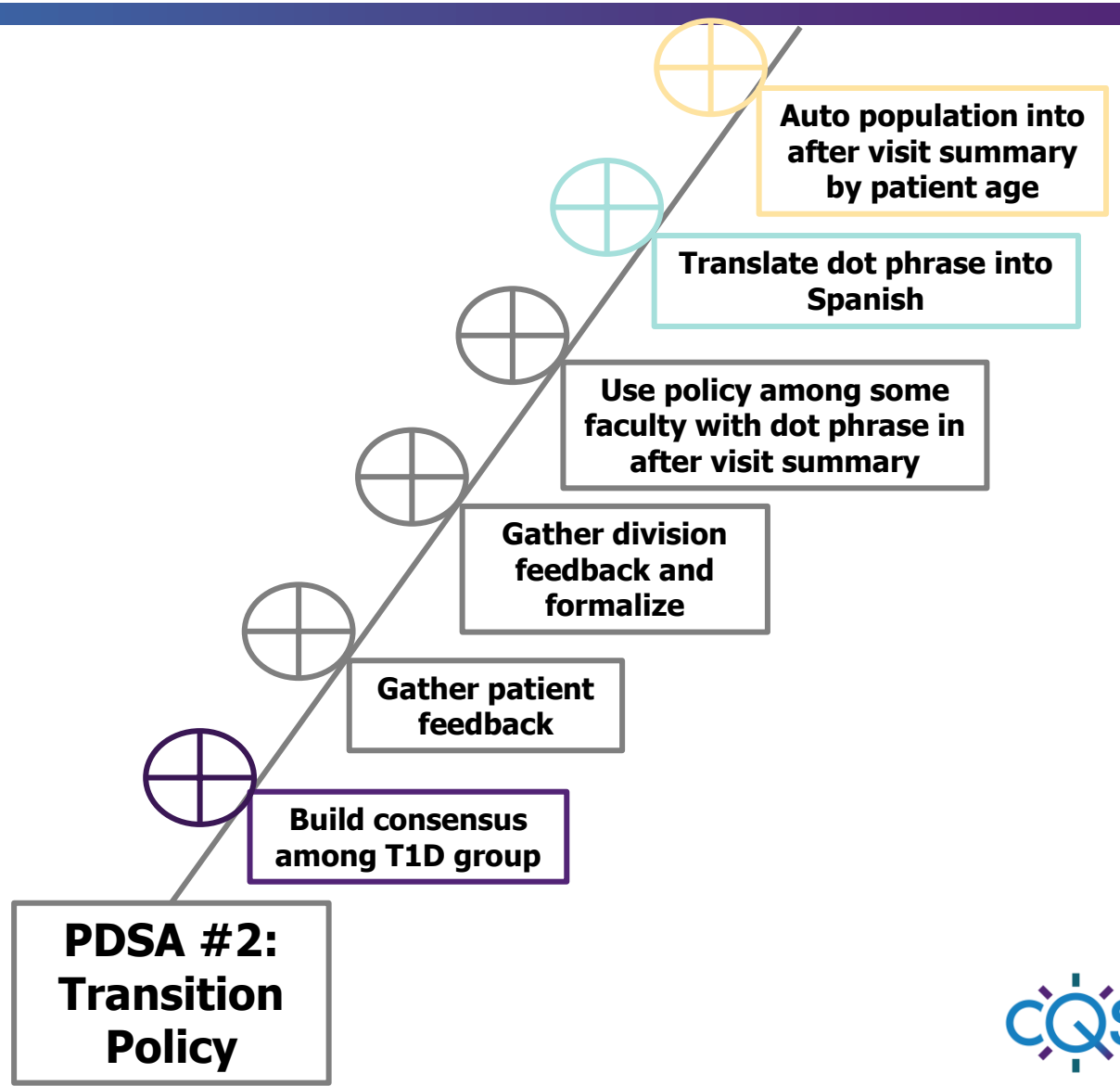
While in pediatric care the parents make most of the decisions, in adult health care the patients make their own medical decisions**. To help get ready for adult care, we will spend some time alone with adolescent patients without the parent/care-giver present starting at age 14 or earlier.** This is important to allow adolescent patients to become more independent in their own health care.

By law, adulthood begins at age 18. We will only discuss your health information with others if you agree. To allow your doctor to share information with your parents or others, consent is required. We have these consent forms at our practice. For young adults who have a condition that limits them from making health care choices, our office will share with parents/care-givers options for how to support decision-making. For young adults who are not able to consent, we will need a legal document that describes the person's decision-making needs.

A successful transfer of care includes assessing your readiness to take over your own care, granting you increasing responsibility, and supporting you as you take on these new skills. It also means researching who and where you would like to transfer care early on so that information can pass smoothly between medical providers.

We look forward to working with your family toward a successful transition during these exciting years.

The Members of the Division of Pediatric Endocrinology.



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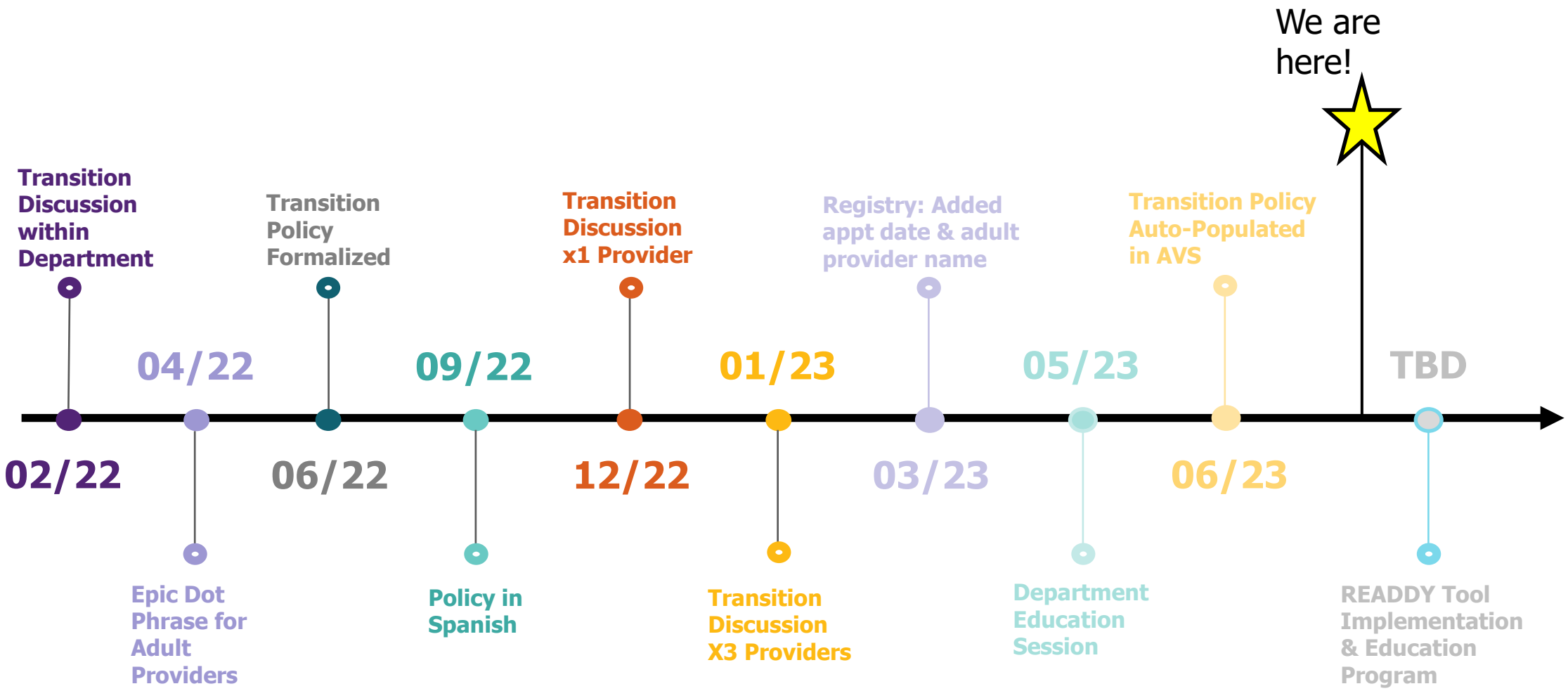
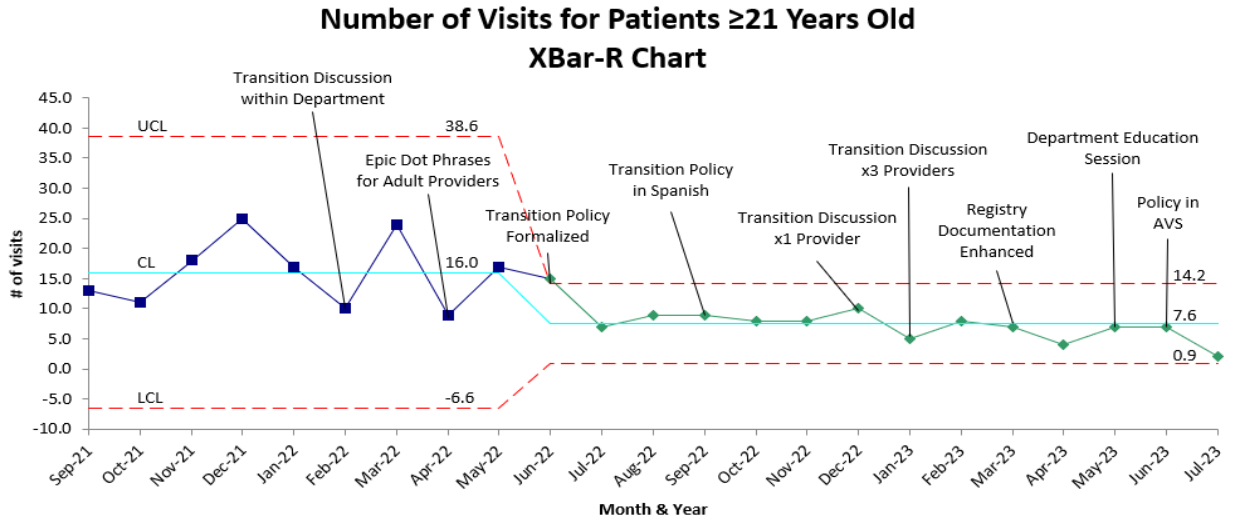
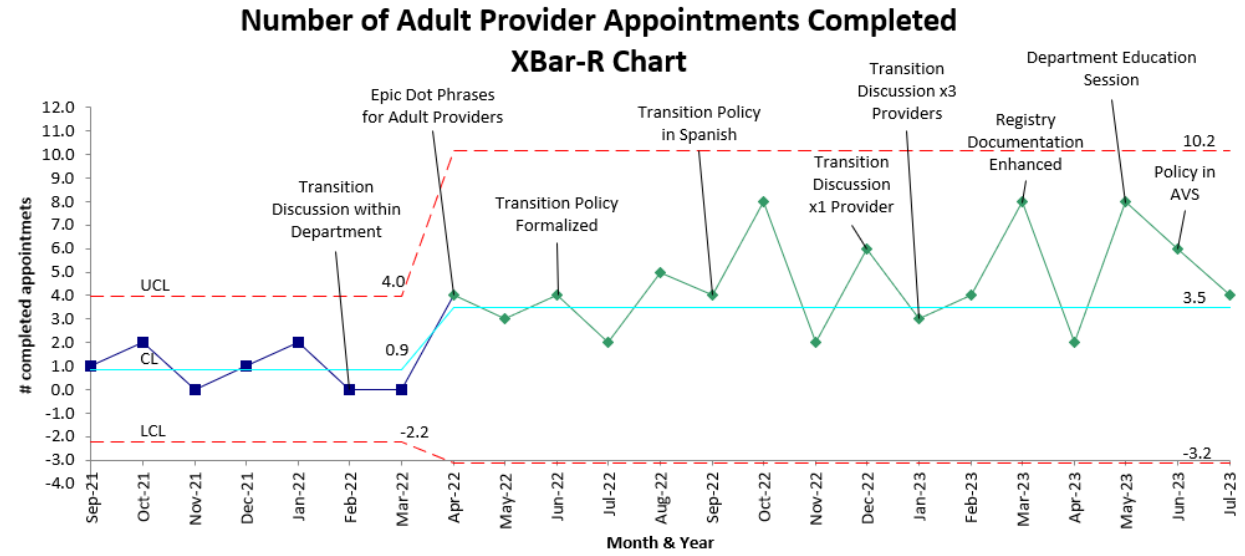
Implementation Timeline



Results- Transfer of Care





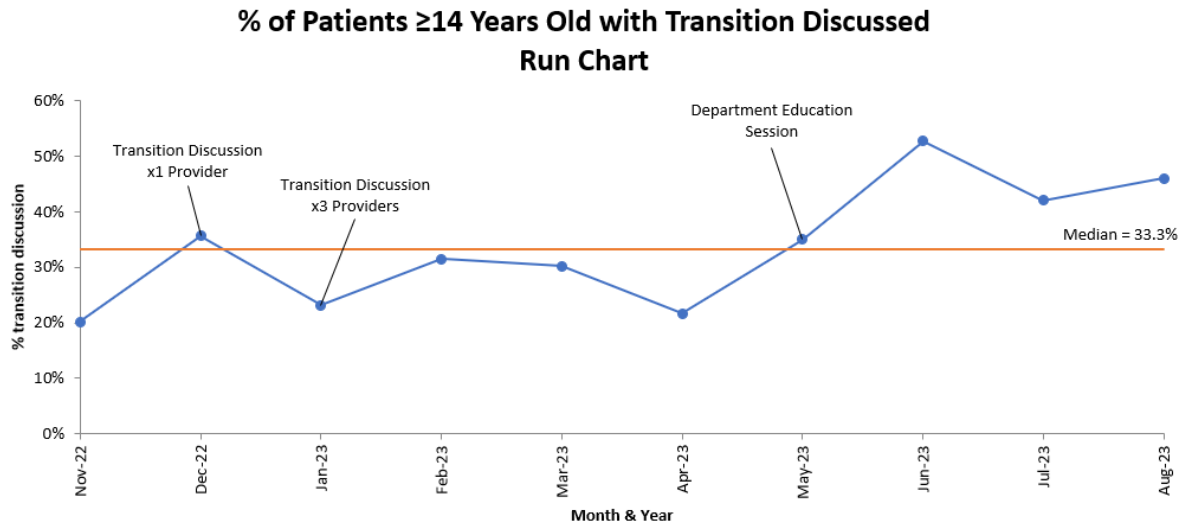
Aim #1: The number of patients ≥21 years old seen each month decreased from 16 to 7.6 visits per month (47.5% decrease)

Aim #2: The number of patients with a completed adult appointment increased from 0.9 to 3.5 completed appointments per month (25.7% increase)

Results-Process Metrics and Balancing Metric

Summary of patient characteristics by transition status,
population includes all patients ≥ 20 years old in the diabetes registry as of 7/31/23

	Transitioned (n=83)	**Not Transitioned (n=109)**
Age (median, IQR)	21 years (20-21)	20 years (20-21)
Females (n, %)	41 (49.3%)	54 (49.5%)
Last HgbA1C (median, IQR)	7.7% (6.9-9.7)	7.8% (7.0-9.1)
Lag Time to Adult Appt in months (mean and standard deviation)	4 (2-8)	NA



Aim #2: Those who transitioned to adult providers did so at an average of 4 months after their last pediatric visit

Aim #3: The number of times that transition discussion occurred in clinic increased over time, though there is no baseline data available

Lessons Learned and Next Steps

- Relatively simple interventions and awareness can have a big impact
- Consensus building is a first step for laying the groundwork for improvement
- Next Steps
  - Transition questionnaire
  - Curriculum Development
  - Adding equity component to registry for tracking

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Thank you!

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- Molly Fruecht RN, CDCES and Carly Heutel LCSW
- Rest of Lurie T1DX QI Collaborative Team: Monica Bianco MD, Maria Chiappetta RN,CDCES, Abby Dieguez MD, Kelsey Howard PhD, Mary McCauley MD, Paula Petrie RN,CDCES, Jill Weissberg-Benchell PhD
- Lurie patients

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Multi-Center Quality Improvement Project: Increasing Documented Transition Plan Across Three Sites in the T1D Exchange Learning Collaborative

Author: Trevon Wright MHA1; Ori Odugbesan MD, MPH1; Donna S. Eng, MD2; Britni A. Schipper3; Jeniece Ilkowitz RN, CDCES3 Emily DeWit MASL4; Osagie Ebekozien, MD, MPH1,5

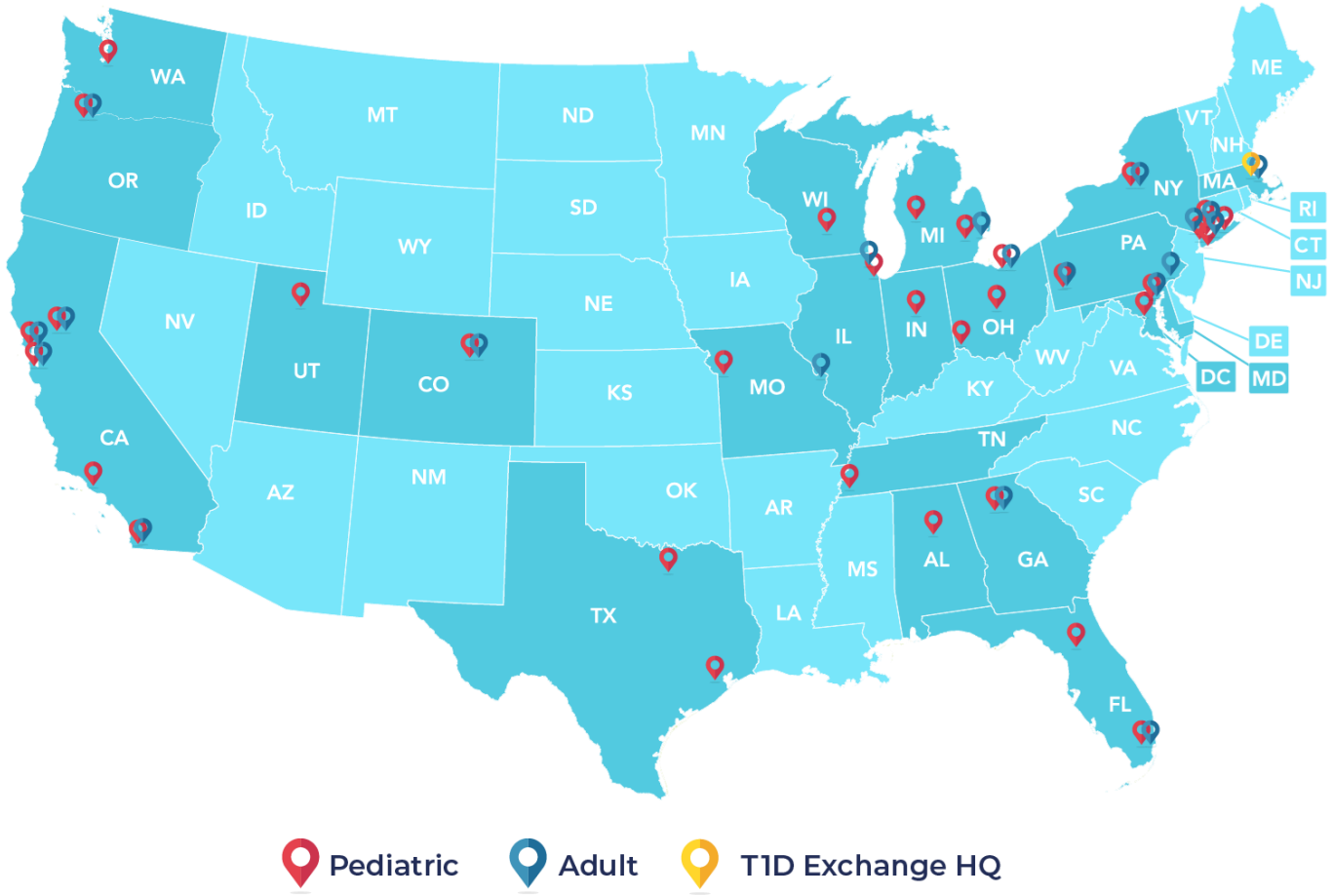
Affiliations: 1)T1D Exchange; 2) Spectrum Health, Helen Devos 3) Hassenfeld Children's Hospital at NYU Langone; 4) Children's Mercy Kansas City, 5) University of Mississippi Medical Center School of Population Health Jackson MS

Disclosure

- None

T1D Exchange Quality Improvement Collaborative (T1DX-QI)

- The T1D Exchange is a Boston-based nonprofit with a mission to improve the outcomes of people with T1D (1).
- T1D Exchange Quality Improvement Collaborative (T1DX-QI) is a learning network that has expanded to 55 clinical centers caring for 100,000+ people with T1D (PwT1D) across 22 US States.



Background

- Young adults with T1D can be at risk for poor glycemic control and adverse health outcomes (2).
- Transition planning improves the quality of care for adolescents and young adults living with T1D as they move from pediatric to adult diabetes healthcare providers (3).
- Our aim was to increase documented transition planning at the participating sites in the T1DX-QI.
- Documented transition planning plays a key role in the quality of care for PwT1D who are transitioning from pediatric to adult healthcare providers (3).
- Studies have shown improved outcomes with transition planning for PwT1D (3).

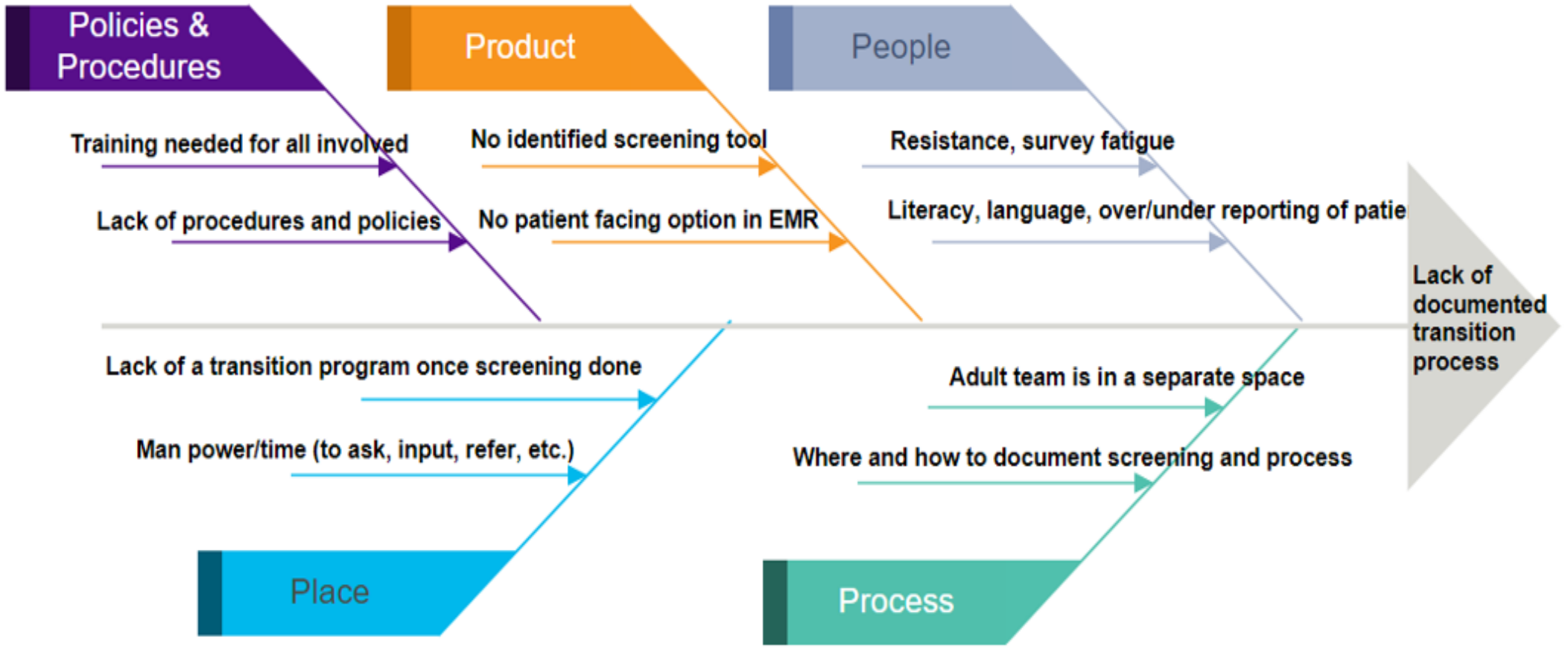
Methodology

- Three T1DX-QI sites: Spectrum Health, Helen Devos, Hassenfeld Children's Hospital at NYU Langone, and Children's Mercy Kansas City utilized QI methodologies to document transition readiness using the READDY assessment tool.
- Monthly data was shared with the T1D Exchange coordinating office using a secure collaborative spreadsheet (www.smartsheet.com).
- Multiple plan-do-study-act (PDSA) cycles were used to develop and expand interventions to increase the proportion of PwT1D with documented transition plans

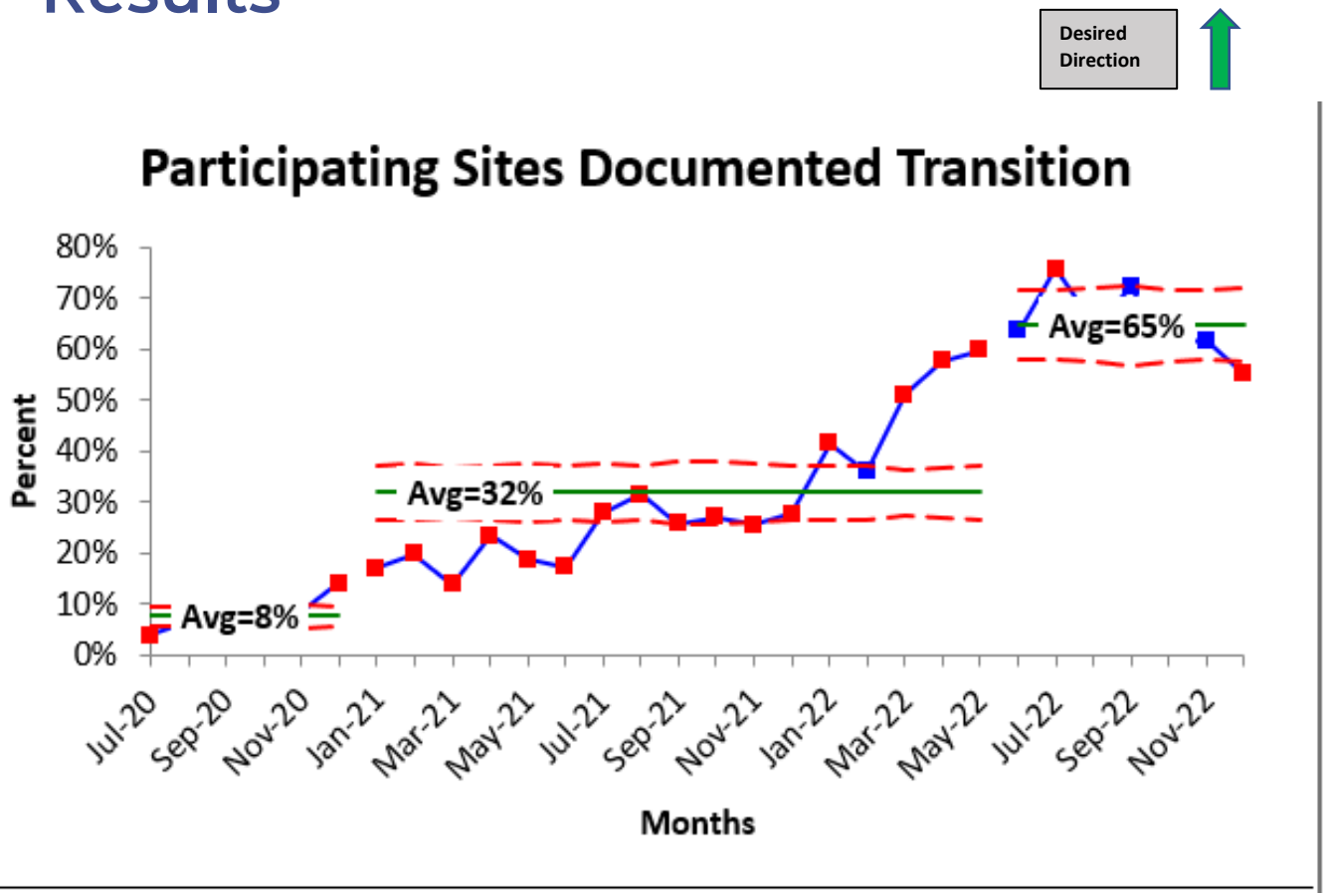
Interventions Tested

- The participating sites tested the following interventions:
  - Provider assignment with a Medical Assistant (MA) and a Certified Diabetes Care and Education Specialist CDCES. In this process, the MA identifies and flags patients eligible for transition planning with the CDCES.
  - Integration of the READDY tool into the Electronic Medical Record.
  - Utilization of RedCap to generate a QR code that was sent to PwT1D ahead of visit.
  - Collaboration with adult clinics to facilitate the referral process.
  - The use of a multidisciplinary team approach including dieticians, social workers, and CDCES and review of reports quarterly.

Fishbone Diagram- Transition Documentation in the Young Adult



Results



- Overall improvement ranged from 27% to 86%. Overall screening using the READDY tool increased from 8% to 65% in 29 months (Figure 1).

Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
262	273	222	202	199	233	218	202	258	210	182	225	179	229	159	167	188	221	231	222	323	262	226	283	283	269	218	271	285	265
10	18	13	15	17	33	37	40	36	49	34	39	50	72	41	45	48	61	96	80	165	151	135	180	214	174	157	165	176	146

Conclusions

- QI methodologies are feasible and useful in testing, scaling and implementing, documentation of transition planning in diabetes clinics.
- The use of the READDY Assessment in pediatric diabetes clinics enables providers to identify barriers that PwT1D face that could have gone undiscovered.
- READDY Assessment is a feasible patient-reported tool in transition planning.

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Utilizing Quality Improvement to Reduce Loss to Follow-up in Pediatric Patients with Type 1 Diabetes

Meenal Gupta, MD

Nov 14, 2023

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Background

- Regular ambulatory diabetes visits offer opportunities for individualized education and development of tailored treatment plans to support the management of T1D
- Higher rates of clinic visit attendance are associated with lower HbA1c levels
- Meeting ADA-recommended quarterly clinic visit frequency remains challenging

SMART Aim

- Reduce the mean loss to follow-up (LTFU) rate for our pediatric patients with T1D from a baseline of approximately 35% to 20% by 18 months

KEY DRIVER DIAGRAM

Inclusion criteria:

- Age <18y
- ICD-10 code for T1D
- At least 1 MD/APP visit in last 18 months

LTFU: last visit >6 months ago

By Oct 1, 2023, the mean LTFU rate for pediatric patients with T1D will decrease from 35% to 20%

Primary Drivers

- Clinic visit scheduling
- Patient population: LTFU cohort
- Provider availability
- Healthcare disparities
- Transportation to clinic
- Language-concordant care
- Patient satisfaction with care

Change Ideas

- Schedule at clinic visit: MA trained to schedule
- Schedule in-between visits: Use Family Service Coordinator (FSC) downtime for outreach calls
- Identify LTFU cohort: Build Tableau dashboard
- Fill unused clinic slots
- Schedule in-between visits: MyChart/FastPass scheduling
- Increase number of providers
- Identify LTFU cohort in EMR: Build Healthy Planet Registry
- Schedule in-between visits: Targeted outreach for patients with higher HbA1c
- Schedule in-between visits: Train RNs to schedule during patient calls
- Schedule in-between visits: Text message reminders for appts
- Offer telemedicine appts
- Hire trained patient navigators
- Social work support and resources
- Interpreter services
- Identify patient preferences using focus groups/surveys

Interventions:

- MA scheduling visit: Adopt
- FSC outreach (Abandoned)
- MyChart/FastPass scheduling: Adopt
- Increase provider access: Adopt
- Pilot intervention: Targeted outreach using Healthy Planet diabetes registry

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Patient Demographics

	All, n (%)	LTFU, n (%)
N	2427	501 (20.6)
Age, Years		
0-5	221 (9.1)	27 (5.4)
6-12	1060 (43.7)	215 (42.9)
13-17	1146 (47.2)	259 (51.7)
Sex		
Female	1167 (48.1)	248 (49.5)
Male	1259 (51.9)	253 (50.5)
Non-Binary	1 (0.0)	0 (0.0)
Race/Ethnicity		
2 or more races	104 (4.3)	14 (2.8)
Asian	99 (4.1)	21 (4.2)
Black or African American	177 (7.3)	39 (7.8)
Hispanic	329 (13.6)	55 (11.0)
Native Hawaiian/Pacific Islander/American Indian	13 (0.5)	3 (0.6)
Non-Hispanic White	1491 (61.4)	318 (63.5)
Other/Unknown/Refused	214 (8.8)	51 (10.2)

Patient Demographics

	All, n (%)	LTFU, n (%)
N	2427	501 (20.6)
Language for Care		
English	2243 (92.4)	464 (92.6)
Spanish	97 (4.0)	15 (3.0)
Other	87 (3.6)	22 (4.4)
HbA1c		
< 7%	287 (14.2)	29 (9.3)
7-9%	846 (41.8)	127 (40.6)
≥ 9%	890 (44.0)	157 (50.2)
Health Insurance		
Private Insurance	1413 (58.2)	242 (48.3)
Public Insurance	935 (38.5)	204 (40.7)
Self Pay	79 (3.3)	55 (11.0)

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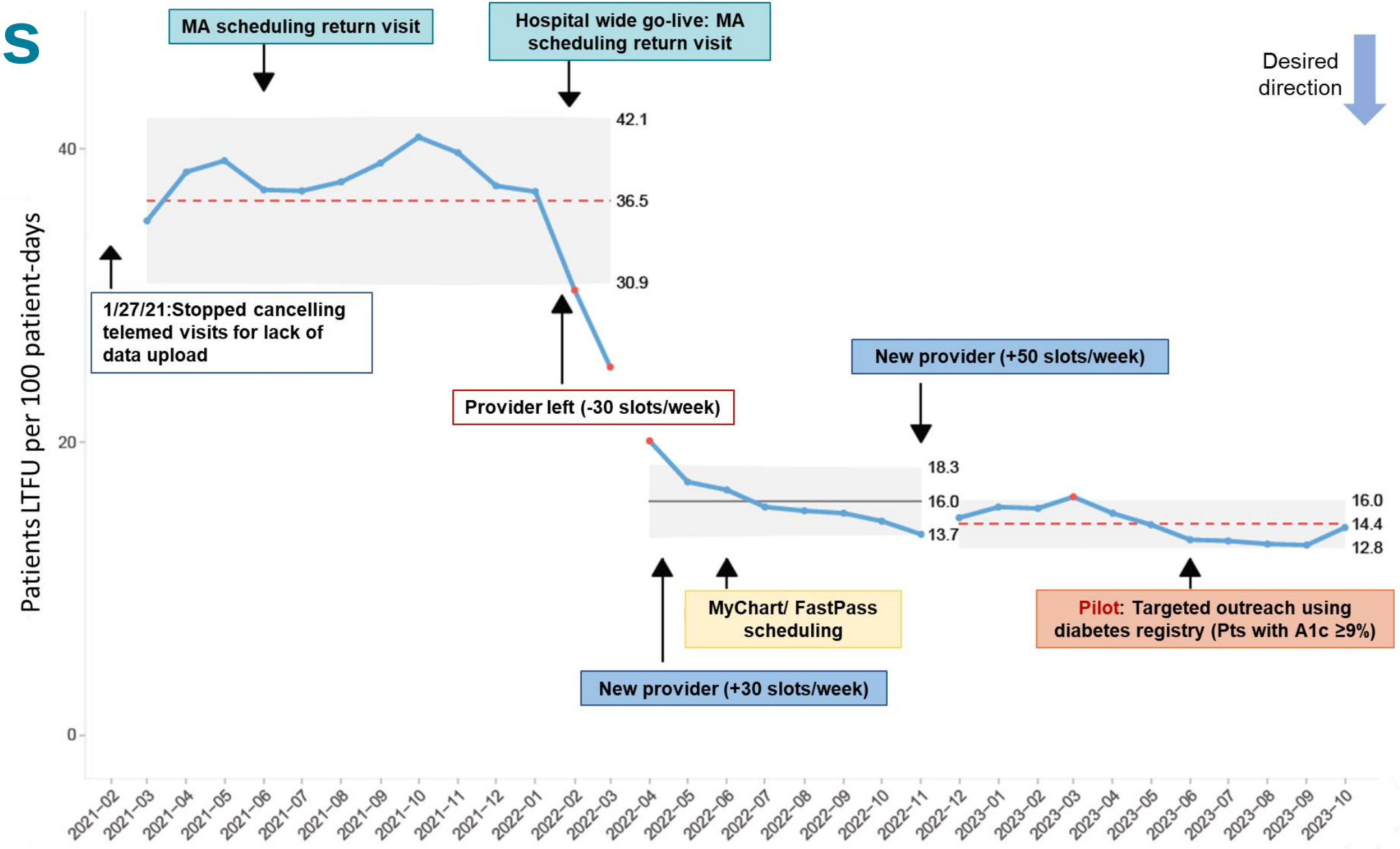
Results



LTFU: last visit >6 months ago

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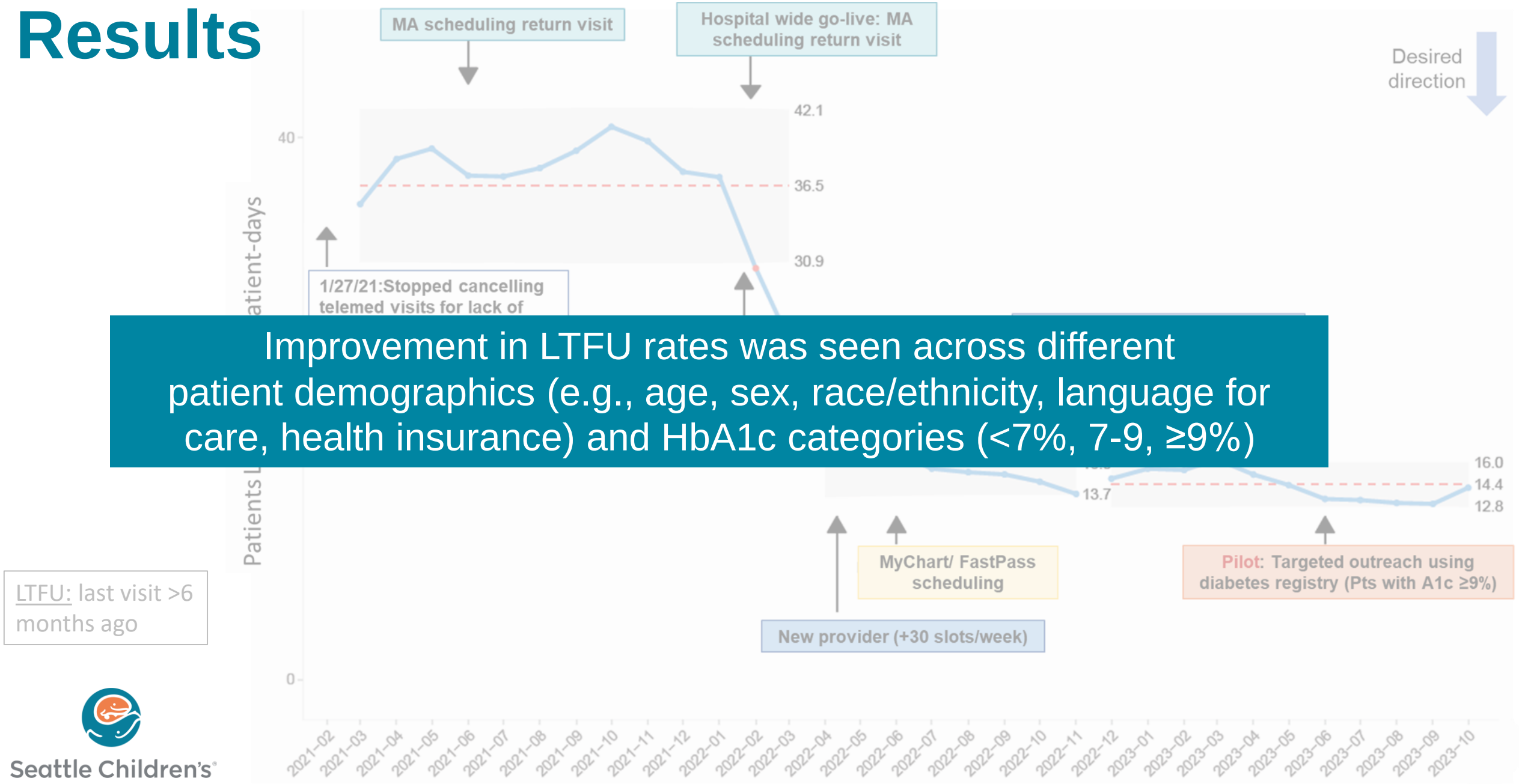
Mean LTFU rate over time

Results



Improvement in LTFU rates was seen across different patient demographics (e.g., age, sex, race/ethnicity, language for care, health insurance) and HbA1c categories (<7%, 7-9, ≥9%)

LTFU: last visit >6 months ago

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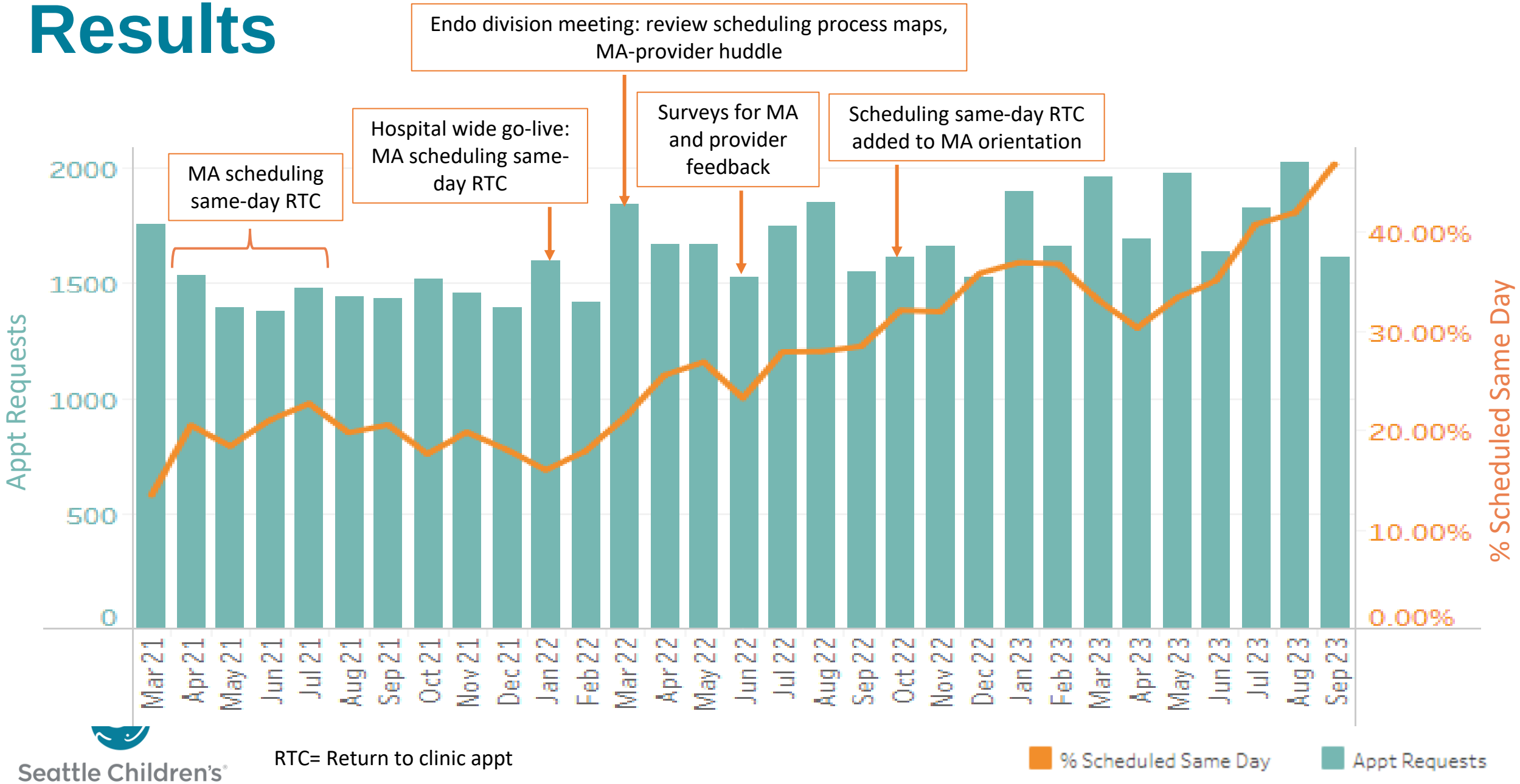
Mean LTFU rate over time

Results



RTC= Return to clinic appt

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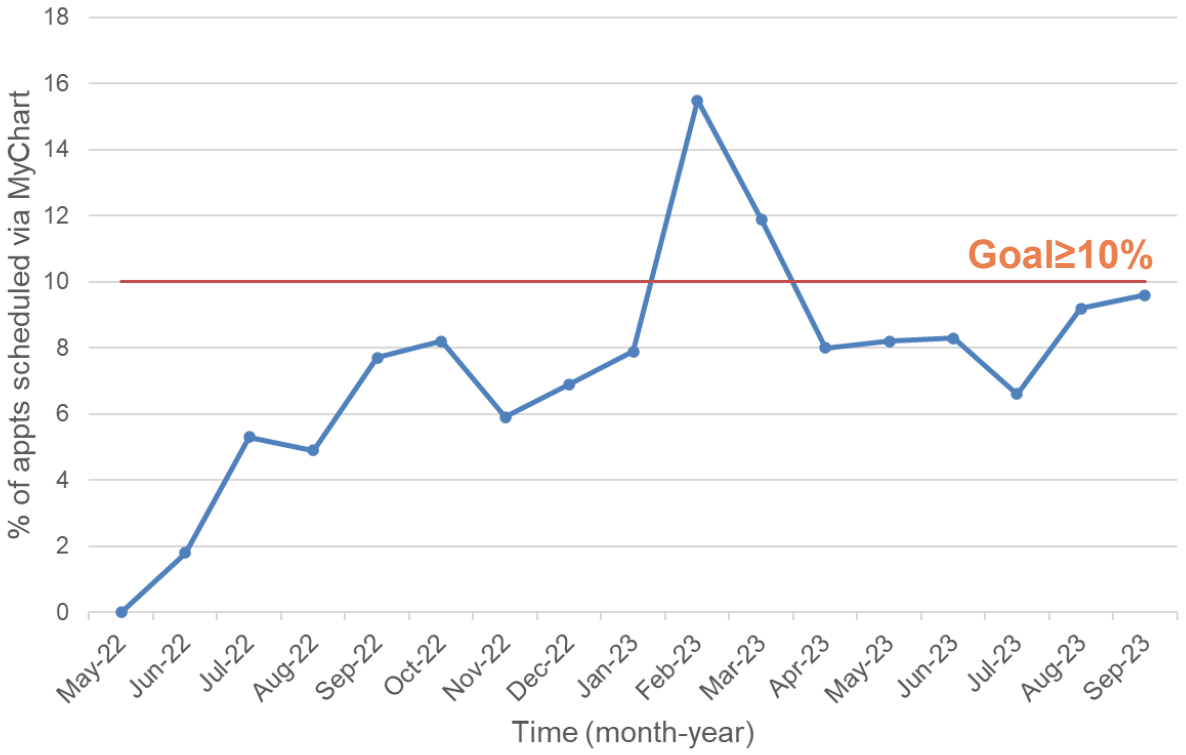
Number and percentage of appointments scheduled the day of visit

Results



Percentage of appointments scheduled via MyChart

Number of FastPass offers sent, offers accepted and appointments completed

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Conclusions

- Improving scheduling processes and visit access using QI methodology resulted in reduced LTFU rates for our pediatric patients with T1D
- Significant improvement in LTFU rates was seen across all patient demographics and HbA1c categories

Next Steps

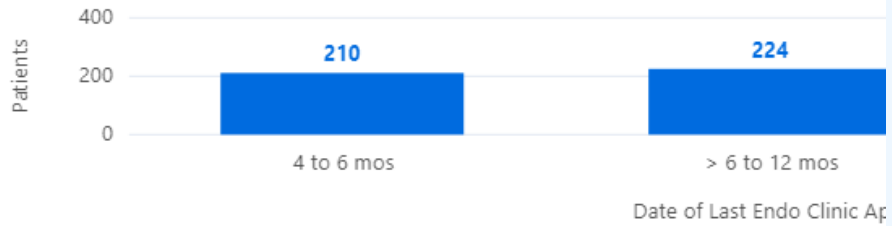
- Use our Healthy Planet Diabetes registry to identify LTFU patients with A1c ≥ 9% and prioritize outbound scheduling calls to these patients to fill empty clinic slots

Next Steps

Diabetes Healthy Planet Registry

Diabetes Type 1

- Type 1 - High Risk HbA1c
- Type 1 - High Risk IP/ED Admits
  Last Refresh: 05:09:20 PM
- Type 1 - Patients by Age
- Type 1 - Sex
- Type 1 - Due for HbA1c
- Type 1 - Due for Clinic Appt
  Last Refresh: 05:09:38 PM



- Type 1 - Due for RD Visit
- Type 1 - Due for SW Visit

Diabetes Registry Patients - Type 1_MG [7920178] as of Thu 10/26/2023 5:20 PM

Chart | Encounter | Research Studies | Generate Letters | HM Modifiers | Add to List | Place Orders | Send Communication | Track Pt Outreach

Detail List | Explore

Filter | Clear All Filters | Re-run Report | Refresh Selected | Select All

Choose a column to filter

Age
From 0
To 18

Last Endo MD/APP Visit Date
From 4/26/2022 (M-18)
To 4/26/2023 (M-6)

Next Appt Date
Has no value

Last HbA1c Value
From 9
To 14

Add Another Filter

Clear All Filters

Last Endo MD/APP Visit Date	Last MD/APP Visit Provider	Next Appt Date	Next Appt Dept	Pt Has Active Endo Appt Req. (Provider Requested)	Last Endo MD/AF Visit Dept
02/16/2023	Sara G Benitez, PA-C			Yes	ENDBCSC
01/31/2023	Vanessa Bruce Waldrep, ARNP			Yes	ENDNOR
03/27/2023	Jessica Tashay Johnson, ARNP			Yes	ENDSOU
03/13/2023	Kearstyn Ann Leu, ARNP,MPH			Yes	ENDSOU
05/05/2022	Erin M Alving, ARNP			No	ENDSPC
02/07/2023	Elena K Martinez, PA-C			Yes	ENDSPC
11/30/2022	Elena K Martinez, PA-C			Yes	ENDSPC

30 of 2428 results match filters

Thank You

- TIDX-QI Site PIs: Faisal Malik, Alissa Roberts
- Practice Manager: Joy Briggs
- QI Program Manager: Yasi Mohsenian
- Statistical support: Kristy Carlin
- Data Analyst: Noah Espinoza
- SCH diabetes clinic leadership team
- SCH diabetes clinical care team

Endo Faculty Sailing Adventure

Endo Group at PEARL 2023

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UCSF Benioff Children's Hospitals

Improving Diabetic Retinopathy Screening and Documentation in Youth with Diabetes

Isabella Niu, MD*; Fatema S. Abdulhussein, MD*; Priya Srivastava, MD; Tina Y. Hu, MD; Barbara Liepman, RN MS, CDCES; Jenise C. Wong, MD, PhD

*Co-authors

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11/10/2023

Background

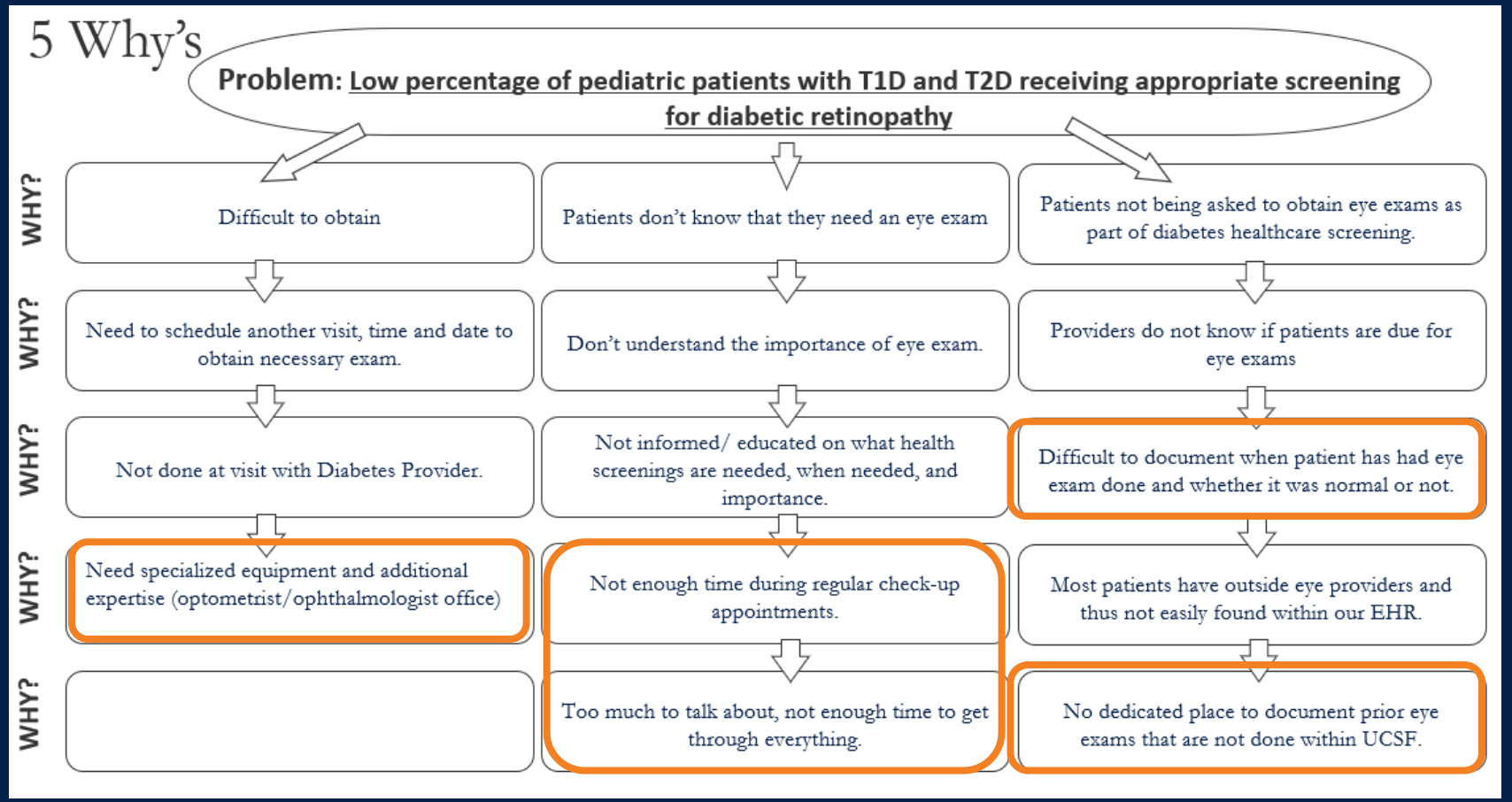
- Diabetic retinopathy (DR) is the most common cause of preventable blindness and visual impairment in young adults
- Screening guidelines (ADA and ISPAD) exist, however, screening rates remain low
- Fundus photography has been recommended to improve access to DR screening

Baseline Data and Objective

DR screening rate in youth < 18 years old with T1D and T2D seen at UCSF Benioff Children's Hospital San Francisco Pediatric Diabetes Clinic was 3.5%.

Methods

- Assessed barriers and root causes for low DR screening rates



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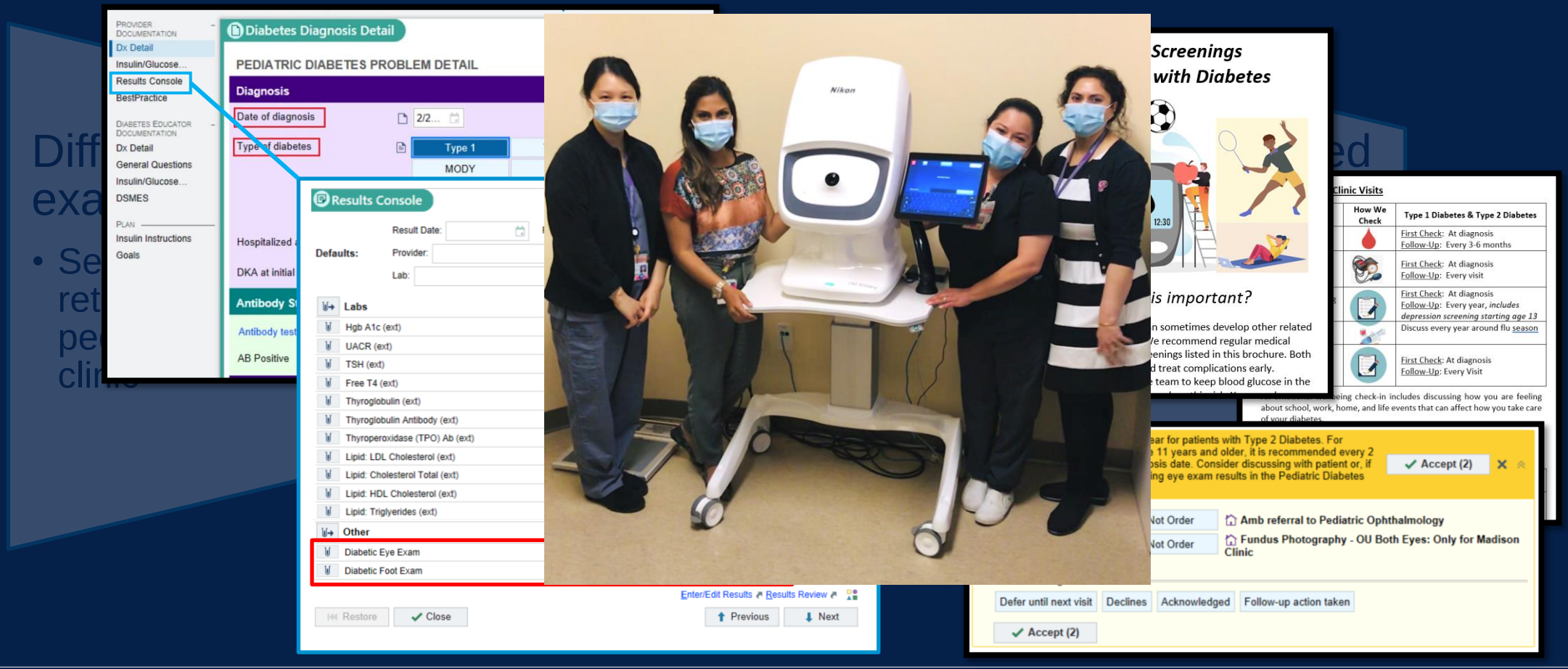

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Results

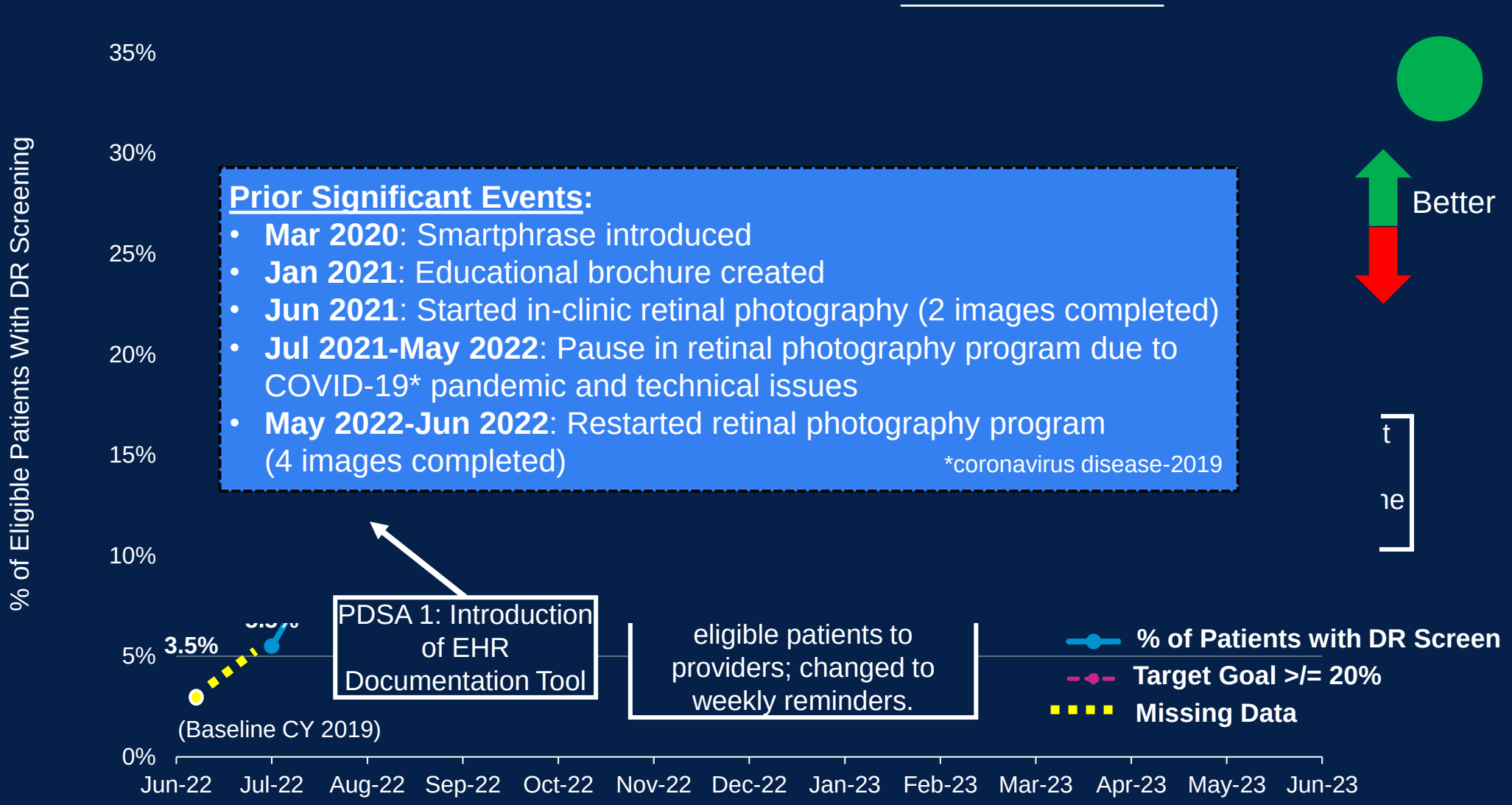

Figure 1: Annotated line graph of the percentage of eligible patients with T1D and T2D with completed DR screens within the past 2 years.

Data source: EHR
Date: July 2023

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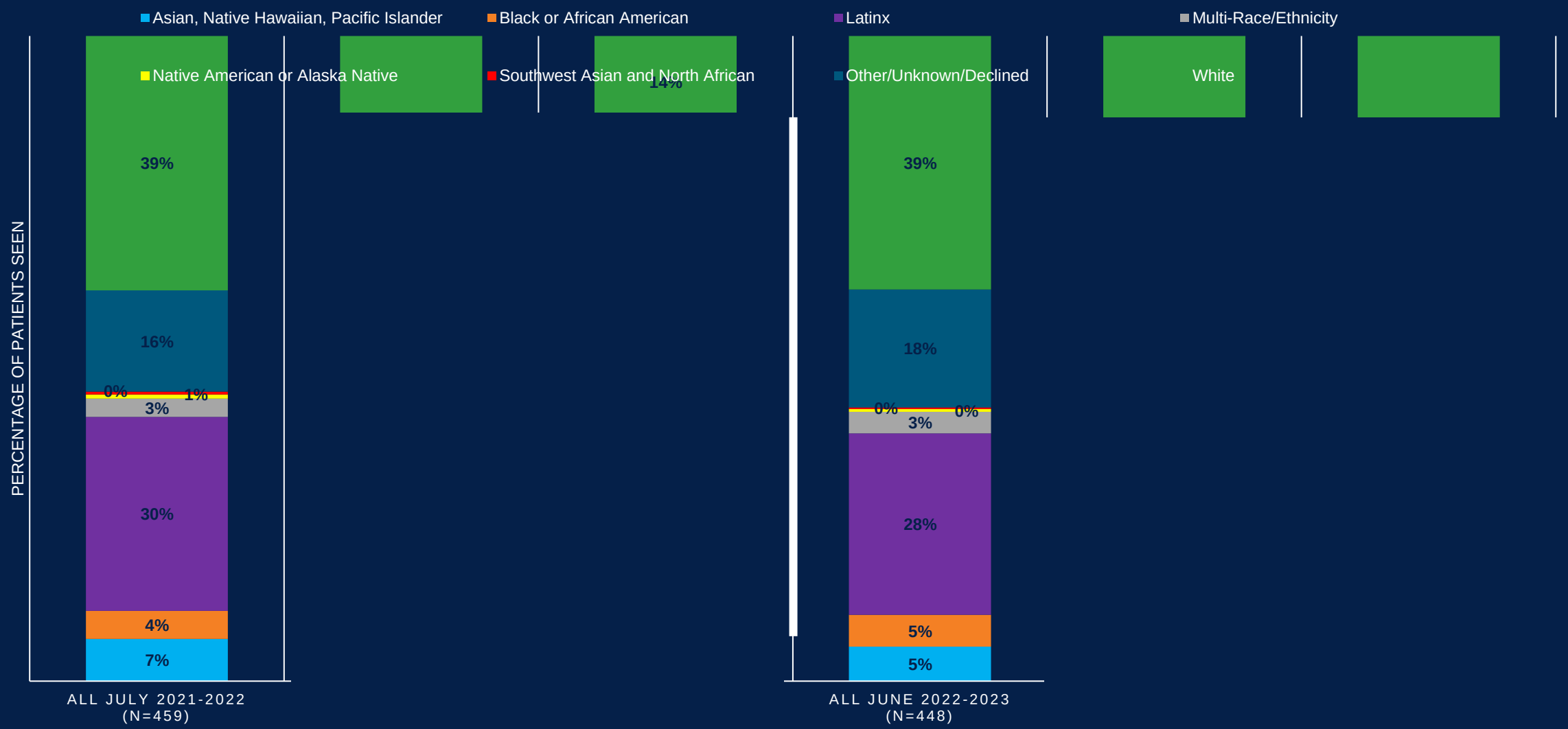
RACE/ETHNICITY OF ALL PATIENTS SEEN AT PEDIATRIC DIABETES CLINIC COMPARED TO THOSE WITH EYE EXAMS



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Conclusions

By implementing an in-clinic telemedicine retinopathy screening program, educating patients and providers on DR, implementing EHR tools, and improving EHR documentation, the DR screening rate among those ≤ 18 yo with T1D and T2D in our Pediatric Diabetes clinic increased from a baseline rate of 3.5%* in 2019 to 32.9% by June 2023.

*Note: in 2019 data only looked at those <18 yo

Workflow

Provider talks to patients about DR & in-clinic fundus photography.

Provider places order and notifies front desk.

CALIFORNIA CHILDREN'S SERVICES (CCS)

CMS Children's Medical Services

COVERED CALIFORNIA

BlueCross BlueShield

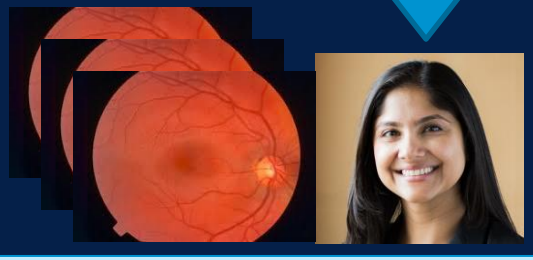
cigna healthcare

Front desk verifies insurance coverage/authorization requirements.

Front desk calls and schedules patient.

Fundus photography performed by MA

(w/in 2 weeks)



Ophthalmologist reads images remotely.

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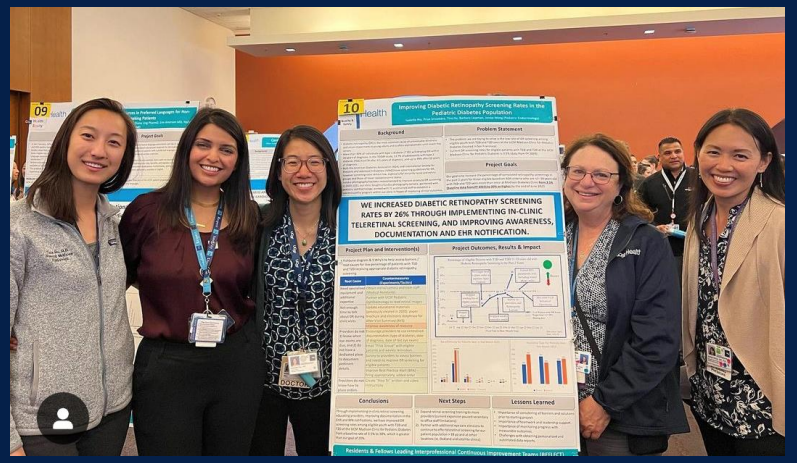

Sustained quality improvement implementation of a transition preparation program for adolescents and emerging adults with type 1 diabetes

Sarah D. Corathers, MD; Rajvi Desai, LSW; Alison Deisinger, RD, CDCES; Rachael Jones, MSW, LISW; Kyle Kaplan MPH; Mary Jolly RN, MBA, CPHQ; Amy Grant, RN, Jessica C. Kichler CDCES, PhD, CPsych

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Background and Methods:

- The purpose of this quality improvement (QI) initiative is development and maintenance of a pediatric T1D transition program for adolescents and emerging adults (AEA) graduating to adult care.

- A multidisciplinary QI team identified key drivers and interventions consistent with Got Transition guidelines (www.gottransition.org)

- SMART aim to increase % AEA with documented transition plan by 20%/year over baseline in ages 16-18 and by 40%/year for ages ≥ 19

- Post-transfer outcomes tracked in convenience samples

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Longitudinal Diabetes Transition Planning:

Sarah D. Corathers, 01.2016

Diagnosis: There is a future with diabetes

Goal: recognition that diabetes extends beyond childhood and there is a future with diabetes

Age 12: Shared responsibility of care

Goal: Child increases participation of diabetes self-management with caregiver and provider

Age 16: Development of independence

Goal: Further development of diabetes self-management and health navigation skills

Age 18-24: Planning Transfer

Goal: Individualize plan for transition from pediatric to adult care

Adult Care

Goals:

- Confidence and competence in self-management
- Established care with adult provider
- Improved quality of life and clinical outcomes

Providers:	Discuss role of patient and parent in care; offer time alone with provider	Ongoing anticipatory guidance, screening and prevention topics	Complete indicated screening; treat identified co-morbidities	
Education Team:		Determine interventions based on patient self-assessment	Track ongoing progress of skill acquisition; update transition plan	
Transition Coordinator:		Readiness assessment during annual visits ; document transition plan	Identify specific timeline and provider for transfer of care	Contact point for adult providers; follow up to ensure successful transfer

CCHMC Diabetes Center Transition Guidelines

Most patients transfer to adult care between ages 18-24, transition plans will be individualized.

- At diagnosis, patients and families learn that diabetes is a lifelong condition
- At early adolescence, *around age 12, patients should be offered alone time* with the physician, nurse practitioner or education team staff.
- *At age 15*, the diabetes care team will work with patients and families to develop a transition care plan that can be updated over time. An annual transition readiness assessment will help direct educational interventions.
- *At age 18*, patients legally become adults. Young adults may provide consent to allow discussion of personal health information with family members.
- All patients, regardless of age are encouraged to involve supportive family, friends and significant others in health care visits and living with diabetes.

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Transition Readiness Assessment

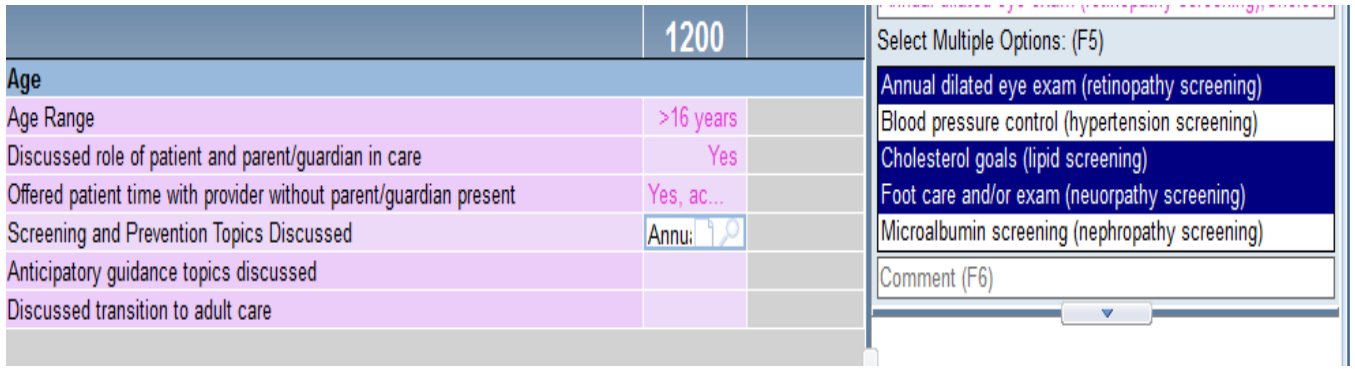
READDY Transition to Adult Type 1 Diabetes Care
How ready are you?

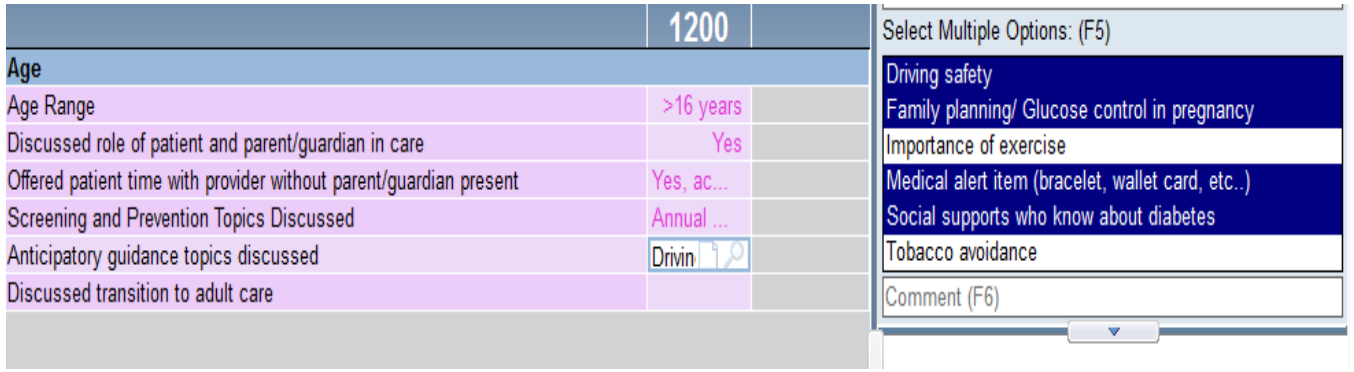
Transition **R**eadiness assessment for **E**merging **A**dults with **D**iabetes **D**iagnosed in **Y**outh

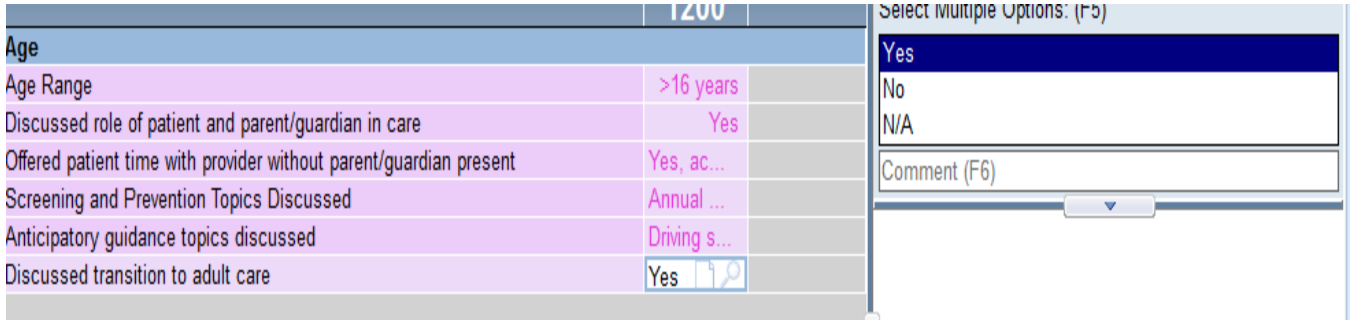
Listed below are some knowledge and skills that are useful in keeping you healthy with diabetes over your lifetime. This is not a test. There are not right or wrong answers. Please try to answer honestly. Be sure to ask your provider if you need more help in any of these areas.

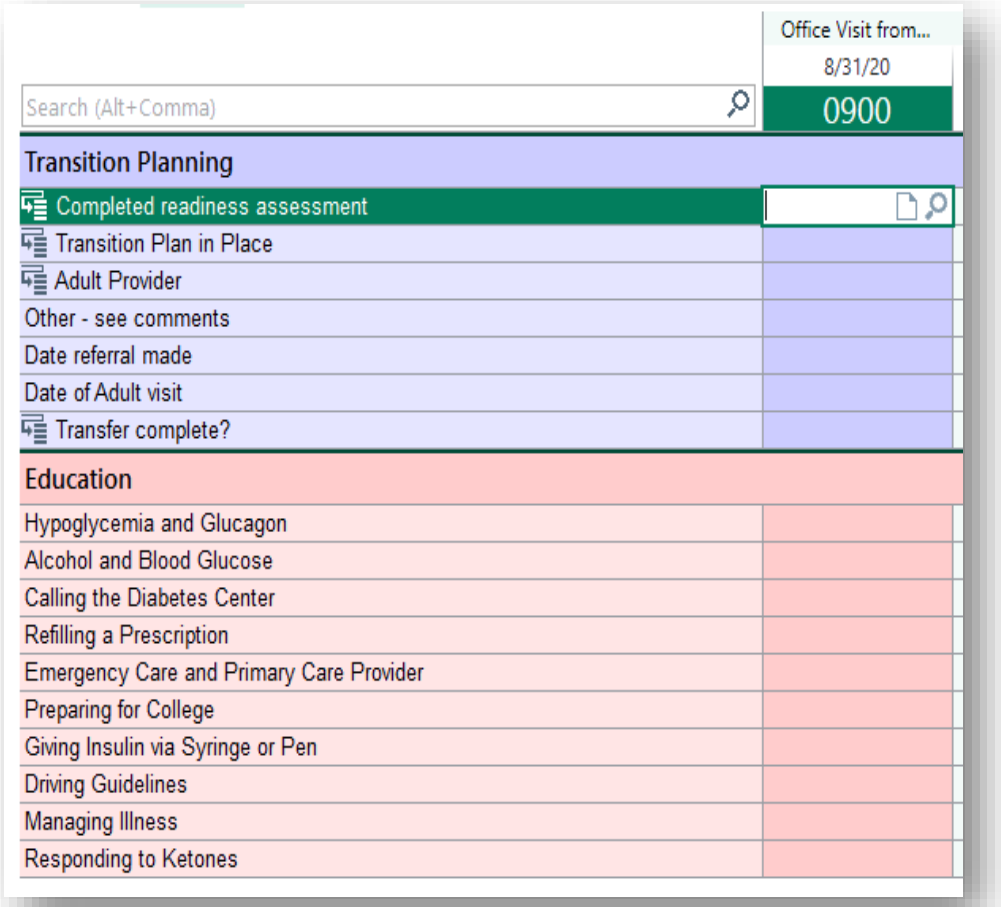
Knowing the facts about diabetes (Knowledge) I am able to:	Yes, I can do this	Somewhat, but I need a little practice	No, I still need lots of practice	I plan to start	Haven't thought about it
Describe diabetes in my own words					
Explain what Hemoglobin A1c (HbA1c) measures					
Recall my most recent HbA1c					
State my target HbA1c					
Understand my current health status					
Describe three long-term problems that might come from high HbA1c					
Teach a friend or roommate about signs of hypoglycemia					
Teach a friend or roommate about treatment of hypoglycemia, including use of Glucagon					
Tell someone how alcohol effects blood glucose					
Explain long-term impact of tobacco on heart health in people with diabetes					
Explain the impact of diabetes on sexual health/function					
Explain the impact of glucose control before and during pregnancy (female patients)					
List examples of tests done in routine visits to identify or prevent complications of diabetes					

Transition Plan









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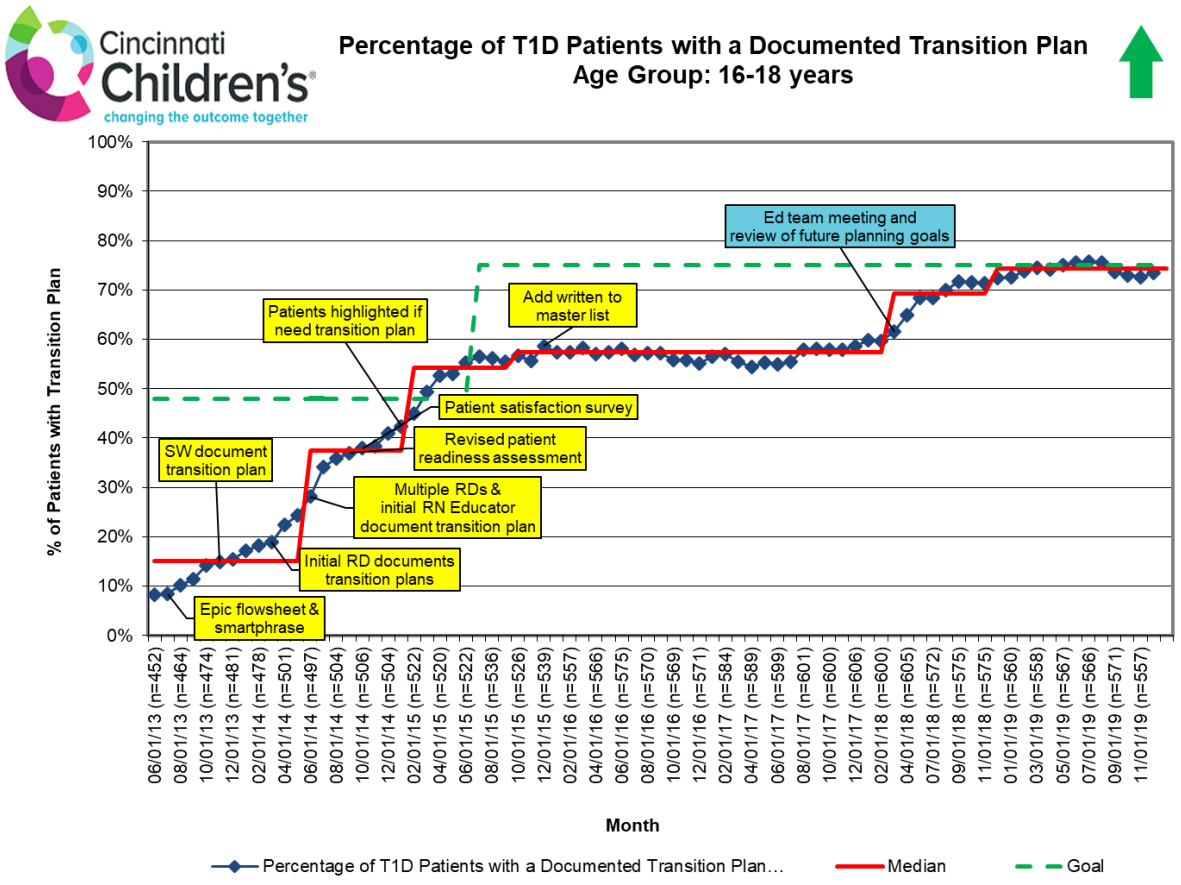
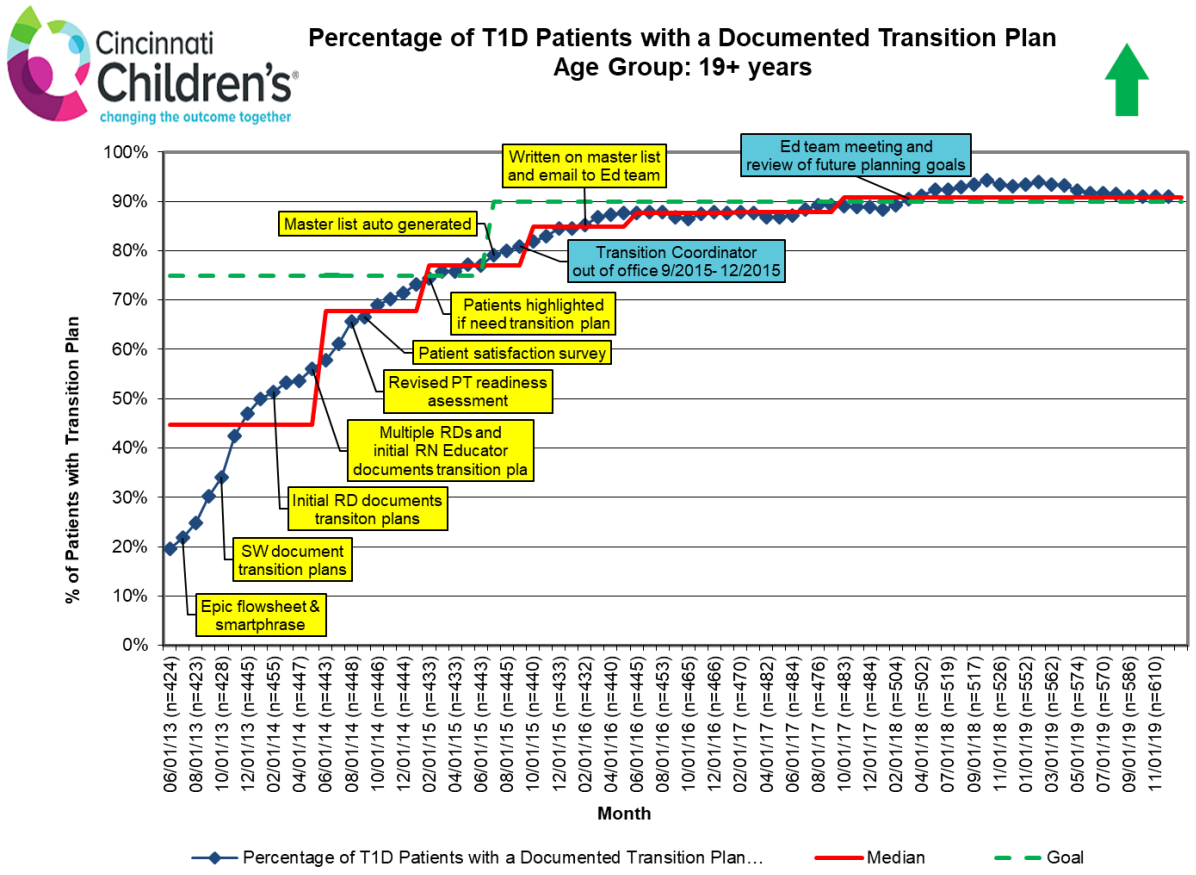
Transition Plan Completion Rates
Active QI 2013-2016; Sustain through 11/2019





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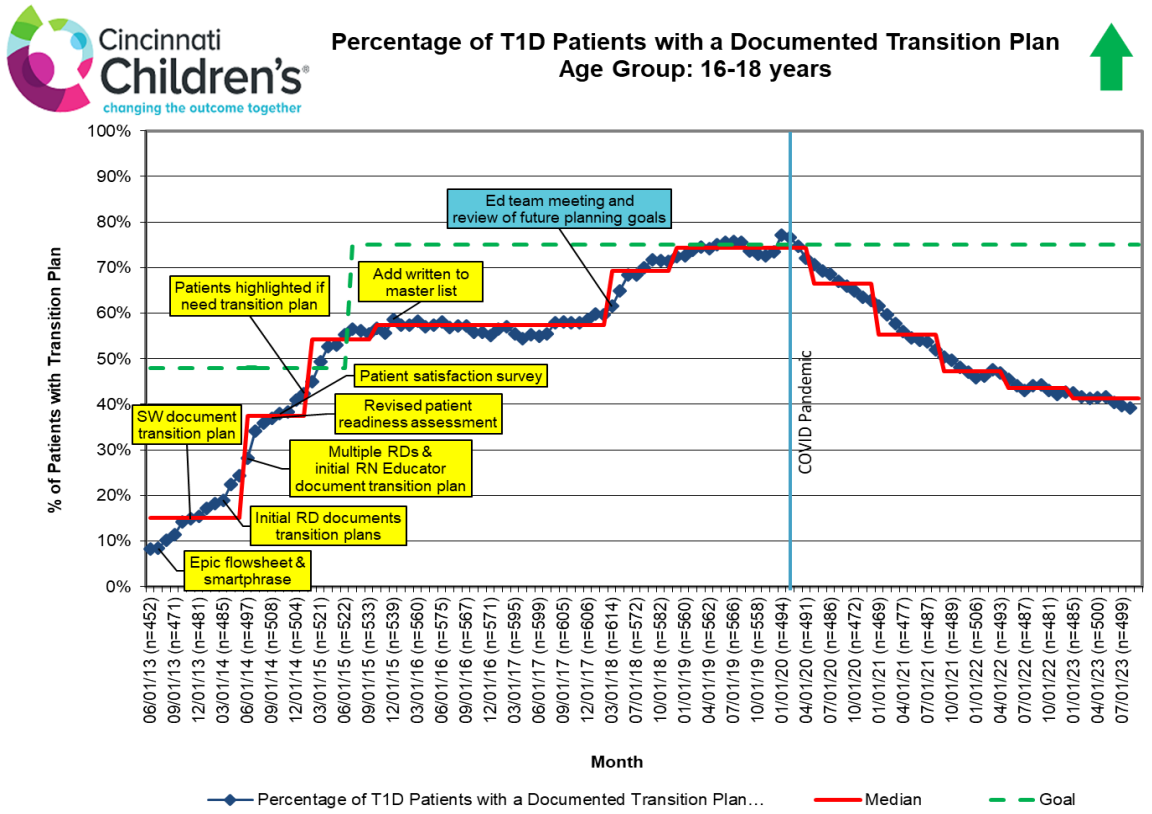
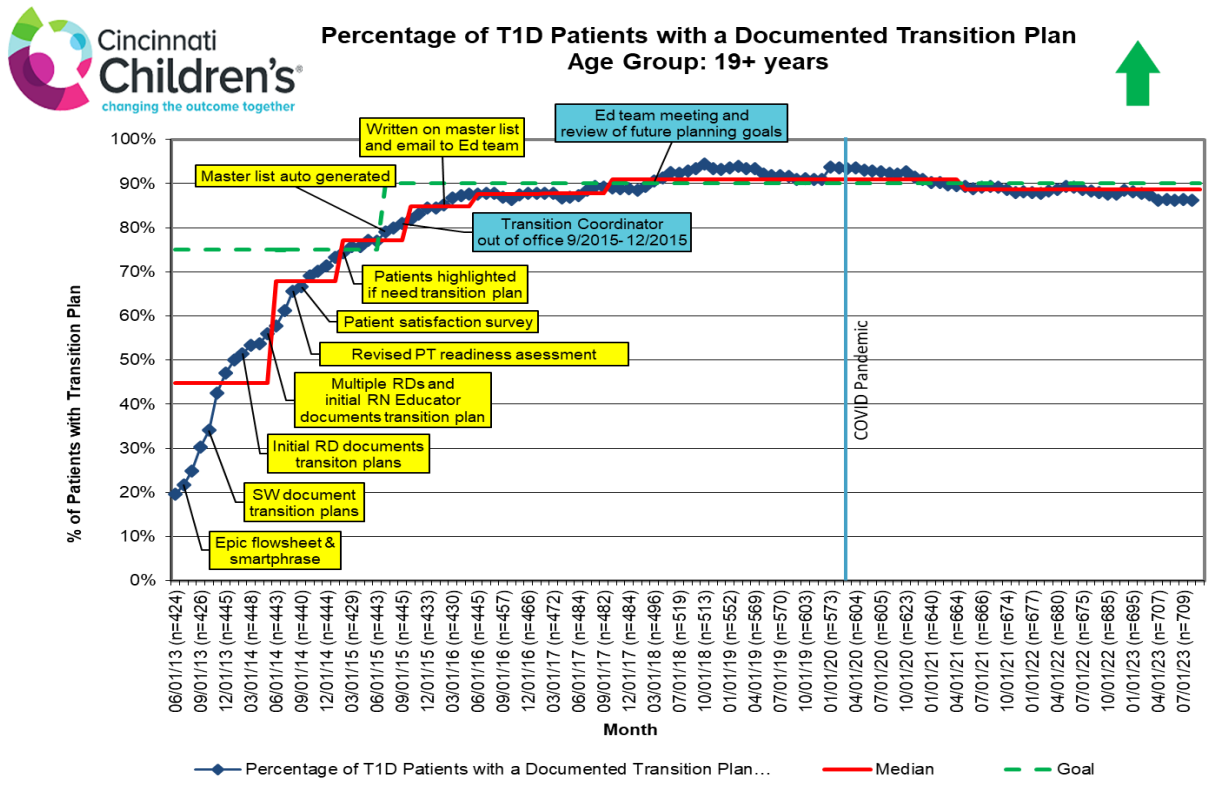
Post-Covid19: Decline in 16-18; Sustained Transition Plan Documentation ≥ 19 years





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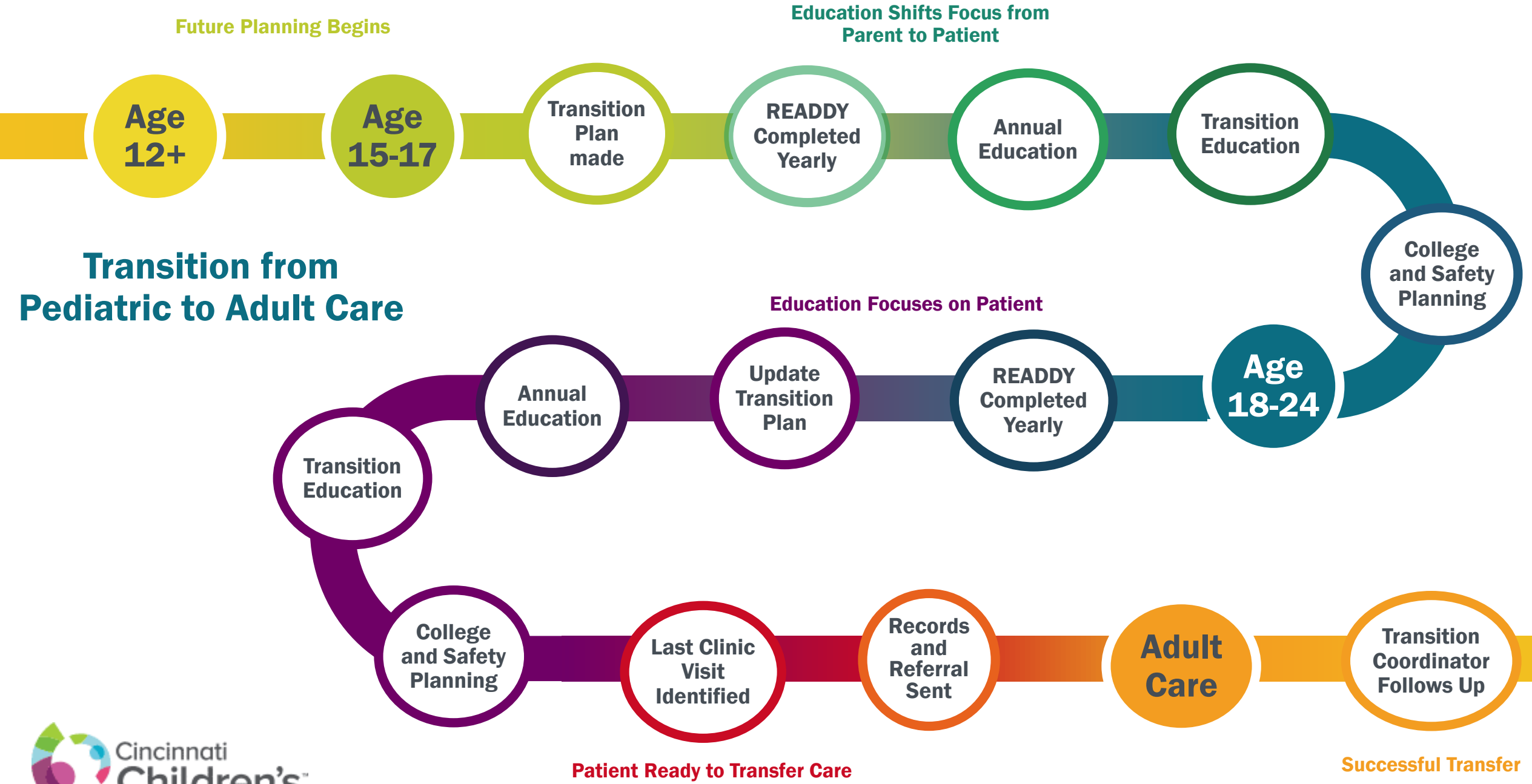
Transition from Pediatric to Adult Care



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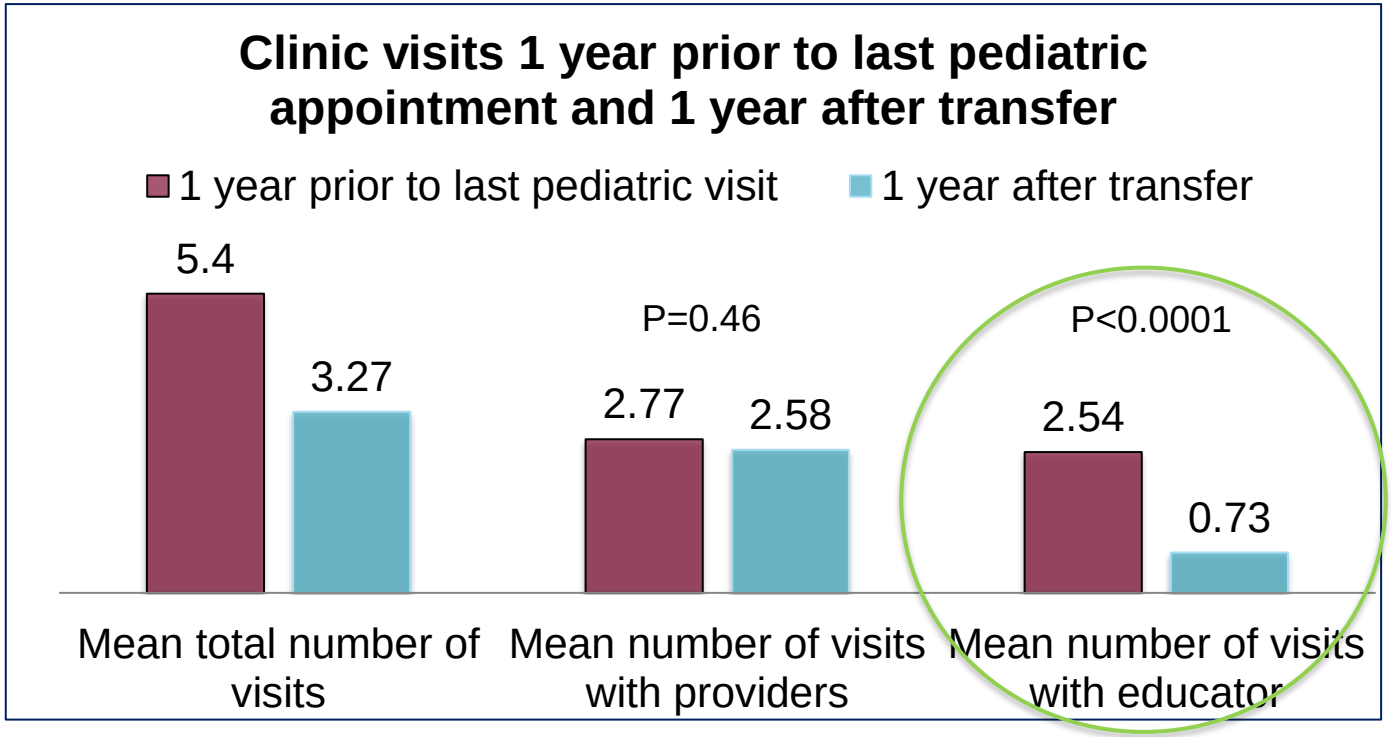
Slide courtesy of Rachael Jones

Post-Transfer

	Patients that have been transferred for 1 year (n=48)
Sex	
Females	23 (48%)
Males	25 (52 %)
Race	
African American	13 (27%)
White	35 (73%)
Type of Diabetes	
Type 1	41 (85%)
Type 2	4 (8%)
Cystic Fibrosis related	2 (4%)
Insulin resistance	1 (2%)
Insurance Status	
Private	28 (58%)
Public	17 (35%)
Self-pay	3 (6%)
Mean Age at Transfer	22.10 years ± 2.19
Mean Duration of Diabetes at Transfer	10.81 years ± 5.08

	Pediatric Care, n=48	Adult Care, n=40
Mean Hemoglobin A1c	8.70	8.59



	Pediatric care N (%)	Adult Care N (%)	P-value
Documented foot exam (within 1 year)	8 (17%)	40 (83%)	<0.0001
LDL (within 2 years)	38 (79%)	27 (56%)	0.0278
TSH (within 1 year)	23 (48%)	21 (44%)	0.1025
Documented eye exam (within 1 year)	21 (44%)	19 (40%)	0.6547
Blood pressure	47 (98%)	47 (98%)	---
Body mass index	48 (100%)	48 (100%)	---

Program Evaluation Since January 2022

- Confirmed transfer to adult care: N=197
  - Number of adult receivership practices: 39
  - Average time between last peds and first adult visit: 232 days
  - Mean age of transfer 23.1 years
  - High risk pregnancy transfer of care: 8

- In 2022, n= 91 transferred and (83/91) 91% had 2+ visits

Conclusions and Next Steps

- Interdisciplinary team successfully used Got Transition framework and QI methods to development a transition preparation program for AEA with T1D
- Increased documented transition plans over 6 years:
  - Increase from 15% to 75% among ages 16–18 years
  - Increase from and 20% to 90% for ≥ 19 years
- Improvement sustained post-Covid in older age group, but performance declined in younger population
- Ongoing opportunities to enhance transition preparation and adult receivership

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